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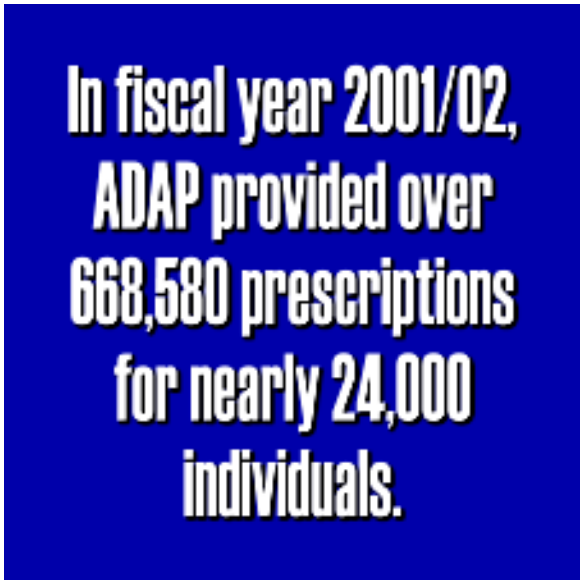
September 2001

Care & Treatment

The OA seeks to assure humane, cost-effective, and appropriate health and support service resources for persons with HIV along the entire continuum of care. To accomplish this goal, the OA coordinates various programs that provide care and treatment services for eligible people infected with HIV and those who have developed AIDS-defining illnesses. These programs include the AIDS Drug Assistance Program, the Early Intervention Program, the Comprehensive AIDS Resources Emergency Health Insurance Premium Payment Program, the local HIV Care Consortia and Direct Services Program, Housing Services, the AIDS Case Management Program, and the AIDS Medi-Cal Waiver Program. These programs are described below.

Comprehensive HIV Care Plan

In January 2001, the HIV Care Branch initiated a planning process to develop a statewide Comprehensive HIV Care Plan to provide guidance for enhancing and improving HIV health care and support services in California over the next three to five years. This plan, due to the Health Resources and Services Administration in early 2003, will describe the organization and delivery of HIV health care and support services as well as identify the disparities in care. The Plan will culminate with a variety of policy recommendations to improve the health outcomes of people with HIV/AIDS in California.



The OA assembled two advisory groups, the HIV Consumer Advisors and the HIV Care Services Advisors (Ryan White CARE Act grantees) to assist in developing the Plan. The HIV Consumer Advisors are a diverse group of persons living with HIV/AIDS representing all geographic regions of the state, while the HIV Care Services Advisors are providers who collectively represent all of the various titles of the Ryan White CARE Act. Each group provides an essential perspective to the OA regarding current service levels, disparities in care, barriers to and gaps in care, as well as strategies to improve the care system. The OA is committed to ensuring that plan development is a coordinated process that includes collaboration with other state and local programs.

AIDS Drug Assistance Program (ADAP)

The ADAP, established in 1987, provides HIV/AIDS drugs to individuals who could not otherwise afford them. Drugs on the ADAP formulary slow the progression of HIV disease, prevent and treat opportunistic infections among people with HIV/AIDS, or treat the side effects of antiretroviral therapy. In direct response to the increased demand for ADAP services, ADAP funding has increased from $17.5 million in FY 1995/96 to $162.9 million in FY 2001/02. ADAP funding for FY 2001/02 is composed of Ryan White CARE Act Title II funds ($87.2 million), the state General Fund ($60.0 million), and statutorily-mandated drug manufacturer rebates ($15.7 million). In FY 2001/02, ADAP provided over 668,500 prescriptions for nearly 24,000 individuals.

ADAP is intended as a program of last resort for people who have no other means to pay for their HIV drugs. Persons with an annual adjusted gross income below 400% of the federal poverty level (FPL), currently $34,460 for a family of one, receive the drugs free. A co-payment is required for anyone whose annual income is between 400% FPL and $50,000.

The OA administers ADAP drug dispensing, reimbursement, and data collection activities through a pharmacy benefit management service provider. The year 2001 marked the second of a five-year contract with Ramsell Corporation (also known as Professional Management Development Corporation) for the provision of ADAP services.

There are over 3,000 participating ADAP pharmacies and 238 local ADAP enrollment sites located throughout the 61 LHJs of California. In addition, clients have access to mail order prescription services upon request. To accommodate client mobility and provide additional access options for clients concerned with preserving anonymity, prescriptions can be filled at any participating pharmacy statewide.

The ADAP Medical Advisory Committee (MAC) meets as needed (generally twice a year) to review the ADAP

formulary, evaluate available HIV/AIDS drugs, and recommend changes to the formulary. As the program's budget allows, new drugs endorsed by the MAC are added to the formulary. Unless prohibitively priced, antiretrovirals are added to the formulary within 30 days of Food and Drug Administration (FDA) approval. The MAC is composed of affected community members, physicians, pharmacists, psychiatrists, AIDS advocates, and county HIV program administrators who are actively engaged in providing and evaluating drug therapy for persons with HIV/AIDS.

As of December 31, 2001, there were 146 drugs on the ADAP formulary. The expanded formulary includes all of the medications listed in the federal *"Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents"* as necessary to treat HIV. The ADAP formulary is posted on the Internet at http://www.ramsellcorp.org and http://www.dhs.ca.gov/AIDS.

Early Intervention Program

The Early Intervention Program (EIP) is a comprehensive, multidisciplinary program that provides care, treatment, and prevention services to HIV-infected Californians. It is a central link in the HIV/AIDS continuum of care, addressing the needs of persons with HIV or AIDS from the time of an HIV-positive test result. If more intensive non-ambulatory AIDS care becomes necessary, the EIP client is transitioned to home- or hospital-based care.

The EIP is designed to prolong the health and productivity of HIV-infected persons and interrupt the transmission of HIV to others. The EIP provides clients with the following range of services:

- Health assessments, medical treatment, and monitoring and laboratory tests;
- HIV transmission risk assessments, risk reduction strategies, and behavior change support;
- Health education, HIV education, and nutrition counseling;
- Psychosocial assessments, short-term counseling, and support groups;
- Assessments of practical support needs, case management, and referrals to other services;
- Benefits and financial management counseling; and
- Other appropriate ancillary services such as assistance with transportation or childcare.

All HIV-infected clients receive a range of program services on a regular basis, based on an individual service plan that reflects the client's needs. HIV-negative, at-risk partners and family members of clients may also receive targeted services such as health and HIV education, risk reduction activities, and couples or family counseling. The EIP model integrates HIV transmission prevention goals and services with care and treatment. A multidisciplinary team provides EIP services.

During calendar year 2001, EIP projects in California provided 37,000 medical services to enrolled clients, 34,661 psychosocial and case management services, 17,201 health education and transmission risk reduction services, and 5,261 other/miscellaneous benefits.

The EIP projects are operated by LHJs, which may subcontract with community-based organizations to provide services. All projects have close, on-going relationships with other HIV/AIDS service providers in their local service areas, thus facilitating referrals and minimizing duplication of services.

The EIP model continues to evolve in response to changes in the epidemic, care and treatment protocols, and funding resources. Since its inception in 1988 through December 2001, the program has served over 18,000 EIP clients. As of December 2001, over 8,900 clients are actively enrolled in EIP Projects/Centers throughout the state. Demographic data indicate that clients in the EIP are 40% White, 33% Latino, 23% African American, 2% Asian/Pacific Islander, and 2% Other/Not Reported.

During calendar year 2001, EIP projects in California provided 37,000 medical services to enrolled clients, 34,661 psychosocial and case management services, 17,201 health education and transmission risk reduction services, and 5,261 other/miscellaneous benefits.

The two original EIP pilot sites continue to operate with federal funds from the CDC, while the remaining 32 sites are supported by the state General Fund. The total EIP budget for FY 2001/02 is $10.3 million.

In order of implementation, EIP sites include:

- *Metropolitan Area Early Intervention Projects*: The 12 Early Intervention Projects established in major urban areas prior to 1990 are located in the counties/cities of San Francisco, Sacramento, Sonoma, Santa Clara, San Mateo, Alameda, Los Angeles, Long Beach, Orange, San Bernardino, Riverside, and San Diego. The total budget for the 12 metropolitan area EIP sites is $3.05 million;

- *Women's Early Intervention Centers*: To improve the health of women through better access to health care, the Women's Health Initiative funded two Women's Early Intervention Centers. The first, WomensCare, opened in April 1995 in Los Angeles. The second, Sister Care, opened in July 1995 serving women in Alameda/Contra Costa Counties. Both centers offer comprehensive EIP services. In FY 1997/98, additional funds were allocated for women's EIP services, and two more sites were opened, one in Contra Costa County, and WomensCare East located in East Los Angeles. A total of $775,000 was appropriated for the four projects;

- *Rural Regional Early Intervention Projects*: In FY 1995/96, the OA adapted the existing urban service delivery model to meet the unique needs of rural areas. Three rural regions, encompassing 22 counties, each received $250,000 to create regional Rural Early Intervention Projects. The North State region includes Butte, Del Norte, Glenn, Humboldt, Lassen, Modoc, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity Counties. The South Central Valley region comprises Fresno, Kern, Kings, Madera, Mariposa, Merced, and Tulare Counties. The Central South Coast region includes San Luis Obispo, Santa Barbara, and Ventura Counties. Each participating county conducted a needs assessment to help design a cost-effective project that responds to local needs. EIP services began in April 1996 in all three regions;

- *1999 Service Expansion:* The FY 1999/00 budget targeted over $1.825 million for the Early Intervention Program. Approximately $770,000 was earmarked to create new sites in five areas not currently served by EIP; These areas include: San Joaquin, Stanislaus, Santa Cruz, Monterey (including San Benito), and Imperial Counties. Funds were distributed via LHJs. An additional $300,000 was allocated in conjunction with funds for communities of color (described below). The remainder of the funding ($755,770) was used to expand capacity at existing EIP sites in 23 service areas; and

- *HIV/AIDS Services to People of Color:* In FY 1999/00, a total of $700,000 of state General Funds was earmarked to develop or expand capacity at EIP sites that serve people of color in Los Angeles, San Francisco, and Alameda Counties. San Francisco implemented EIP services in the Bayview-Hunter's Point area, Alameda implemented men's services in Oakland that are co-located with Sister Care EIP services for women, and Los Angeles County implemented services at the Hubert H. Humphrey Comprehensive Health Center.

HIV Transmission Prevention Program

A defining aspect of the EIP is the emphasis it places on prevention efforts directed to HIV-infected clients who are receiving care and treatment services. In 1999, the OA designed and implemented the HIV Transmission Prevention Program (HTPP), a demonstration project and collaboration between the HIV Care Branch and the HIV Education and Prevention Services Branch. HTPP is designed to provide intensive HIV transmission prevention for persons at high risk for HIV. The project has two distinct segments:

1) Interventions targeting high-risk, HIV-negative individuals (supported through state General Funds); and

2) Interventions targeting HIV-positive persons (supported through federal CDC funds).

Although the two segments are separately funded and differ in some respects, they share the fundamental goal of preventing HIV transmission. For more information on the HTPP component focusing on high-risk, HIV-negative persons, please refer to the Education and Prevention chapter of this report.

The largest component of HTPP, funded by the CDC, targets HIV-positive persons and is implemented in 11 LHJs at ten EIP sites (Humboldt, Riverside, Fresno, Long Beach, Orange, Los Angeles, Santa Barbara, Santa Cruz, Santa Clara, and Ventura Counties). The target population is EIP clients who

have multiple, complex problems and/or who have significant difficulty initiating or sustaining practices that reduce HIV transmission.

At each site, Risk Reduction Specialists, who must have a graduate degree in social work or psychology and experience in working with high-risk behaviors, focus intensively and exclusively on factors influencing transmission behaviors. Concurrently, the client participates in all other components of the EIP: medical services, health education, psychosocial assessment, and support and case management. Interventions utilized are based on the CDC's "prevention case management" model as well as demonstrated behavior change approaches such as harm reduction.

The OA coordinates with experts from a variety of fields to provide training for the Risk Reduction Specialists. In addition, the Specialists from both project segments meet quarterly to receive training, discuss cases and interventions, and to review project evaluation information that is used to inform continuous improvement of the program.

Evaluation of the EIP-based HTPP sites is being conducted by the CDC in collaboration with the Health Resources Services Administration (HRSA), Emory University, and Abt Associates, as part of a national evaluation of the entire demonstration project. In addition, the University of California, Davis, Center for Health Services Research in Primary Care was selected through a request for application process, to conduct an evaluation of both the EIP-based project (working with HIV-positive persons) and the counseling and testing sites (working with HIV-negative persons). State General Funds support this component of the evaluation, which will measure the efficacy and utility of the program as well as explore both client and provider opinions about the services provided.

Bridge Project

The Bridge Project is supported in part by supplemental funding provided through the CDC as part of California's HTPP and by the state General Fund. Its purpose is to prevent further transmission of HIV in communities of color that are disproportionately affected by HIV infection, through increasing the number of HIV-infected individuals successfully enrolled in comprehensive HIV treatment and prevention services.

The Bridge Project operates out of 12 EIP sites serving communities of color. The project is a specific response to the fact that many persons of color do not seek treatment until advanced stages of disease progression, have lower rates of retention in treatment programs, and have lower adherence to medication regimens. The goal of the project is to bridge the gap between HIV testing and treatment.

The EIP has learned that immediate referral into care that requires assessments, appointments, and multiple contacts with unfamiliar persons, in addition to coping with an HIV diagnosis, may actually drive some clients away from treatment. Building trust and overcoming these barriers helps to insure that a previously marginalized client is more likely to maintain an ongoing relationship with treatment providers.

The Bridge person (ideally a member of the community they serve) becomes a link between testing and care and treatment services to reduce racial, cultural, or other barriers to treatment. They provide home or field visits, supportive counseling, information, education, assistance with referrals, and assessment of the clients' readiness to move into additional services. The Bridge person plays an active role on the EIP case management team even before clients are fully enrolled in services.

Additional funding has allowed Bridge staff to be trained as HIV treatment educators, enabling them to assist clients in understanding treatment options, making treatment decisions, and reducing barriers to remaining in treatment or adhering to medication regimens. The Bridge Project is included in the CDC's national evaluation of its demonstration projects as well as in California's evaluation of HTPP.

Because of recent funding provided by the CDC and HRSA, the Bridge Project has expanded from the original 13 Bridge workers to 22 positions statewide. From August 1, 2001, through December 31, 2001, Bridge workers have engaged 150 clients; 58% of these clients being African-American, 24% Latino/a, and 4% Asian/Pacific Islander.

HIV Diagnostic Assay Program

Viral Load Test Program

The Viral Load Test Program (VLTP), established in FY 1997/98, continues to be a collaborative effort between the OA and the Viral and Rickettsial Disease Laboratory in Berkeley. The VLTP provides viral load tests for HIV-infected persons who are uninsured, are not Medi-Cal beneficiaries, and have an annual adjusted gross income below $50,000.

This diagnostic test measures the extent of HIV in the blood. HIV RNA levels in blood usually correlate with an advanced state of disease; thus the test is a good indicator of disease progression. Program utilization has increased from 10,000 tests performed in FY 1997/98, to 30,000 tests performed in FY 2000/01. The tests are provided at approximately 150 HIV service sites statewide. Thirteen regional public health laboratories throughout the state process the tests. Total funding for FY 2001/02 is $2.8 million in state General Funds.

HIV Resistance Test Program

Established in FY 2000/01, the Resistance Test Program (RTP) provides HIV resistance testing services for low-income, uninsured HIV-positive individuals. Similar to the VLTP, the RTP is a collaborative effort between the OA and the Viral and Rickettsial Disease Laboratory. This diagnostic tool measures the degree to which an individual's HIV has become resistant or less sensitive to medications. Currently, there are two types of resistance testing assays, genotypic and phenotypic. During the first year of operation, approximately 738 resistance tests were conducted. The demand for tests is expected to increase as physician awareness of the program becomes more widespread. Approximately 5,000 tests will be available per year, utilizing a variety of commercial, academic, and public health laboratories. Total funding for this program in FY 2001/02 is $3.2 million (including $1 million from the state General Fund).

UCSF Psychosocial Trainings

The OA has an interagency agreement with the University of California, San Francisco to provide trainings to HIV medical/social service providers entitled, "Psychological Challenges of HIV Adherence." Four trainings were held during 2001 and additional trainings are scheduled during 2002. The goals of the statewide trainings are to:

- Enhance providers' effectiveness in confronting the psychosocial issues clients may be dealing with as a result of new treatments; and
- Afford providers the skills necessary to work with their clients in adhering to demanding drug regimens.

The training is offered to all OA-funded service providers.

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

The federal Ryan White CARE Act established a variety of AIDS programs under five titles or parts:

- Title I, the Emergency Relief Grant Program, provides emergency funding to eligible metropolitan areas (EMAs) hardest hit by the HIV epidemic. There are nine EMAs in California (Los Angeles, Oakland [Alameda and Contra Costa Counties], Santa Rosa/Petaluma [Sonoma County], Riverside/San Bernardino, Sacramento [Sacramento, Placer, and El Dorado Counties], San Diego, San Francisco [San Francisco, San Mateo, and Marin Counties], San Jose [Santa Clara County], and Santa Ana [Orange County]) that receive Title I funds and administer them at the local level;
- Title II, the HIV CARE Grants program, provides formula-based financial assistance to states. In California, Title II funds are administered by the OA and are described in more detail below;
- Title III, Early Intervention Services, provides competitive grants for early health care intervention, counseling, testing, and treatment services. Title III programs are administered by HRSA; and
- Title IV provides coordinated services and access to research for women, infants, children, and youth. Title IV also addresses notification and training programs for emergency response programs.
- Part F includes the HIV/AIDS Dental Reimbursement Program, Special Projects of National Significance (SPNS) and AIDS Education and Training Centers (AETCs).

Ryan White CARE Act: California Allocations for Federal FY 2001

TITLE	AMOUNT
Title I (Eligible Metropolitan Areas)	$121,899,322
Title II (State Formula) (Minority AIDS Initiative) (Emerging Communities)	$32,212,366 $663,270 $131,918
Title II (ADAP)	$75,961,117
Title III (Competitive Projects)	$14,712,177
Title III (Planning and Capacity Building)	$1,538,261
Title IV (Competitive Projects)	$5,205,006
Part F (SPNS)	$2,708,316
Part F (Dental)	$1,112,701
Part F (AETC)	$6,147,786
TOTAL	$262,292,240

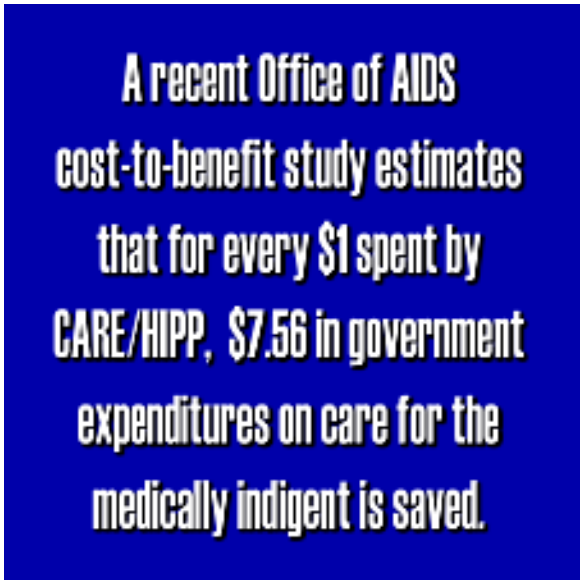
California Department of Health Services, Office of AIDS, January 2002

The table on the preceding page shows California's Ryan White CARE Act funding for federal FY 2001, based on information provided by HRSA.

Through Title II of the Ryan White CARE Act, HIV CARE Grants provide financial assistance to states to improve the quality, availability, and organization of health care and support services for individuals and families with HIV disease. California used its Title II grant in federal FY 2001 to operate local HIV Care Consortia, provide home- and community-based care services for individuals with HIV disease, assure the continuity of health insurance coverage, and support ADAP.

CARE/Health Insurance Premium Payment Program

The CARE/Health Insurance Premium Payment Program (CARE/HIPP), funded under Title II of the Ryan White CARE Act, helps people with HIV/AIDS maintain their private health insurance coverage. Because participants' health insurance policies must cover outpatient prescription drugs, the program also helps ensure that CARE/HIPP clients have access to AIDS drugs, and preserves ADAP access for clients with no other method of obtaining drug coverage.



The goals of CARE/HIPP are to:

- Continue private health insurance policies for people disabled as a result of HIV/AIDS until they transition into the state's Medi-Cal/HIPP program, a County Organized Health System HIPP program, or Medicare, whichever comes first;
- Reduce the fiscal impact on ADAP and other publicly funded health programs; and
- Ensure continuity of ongoing access to therapeutic services for people with HIV/AIDS.

CARE/HIPP clients must meet financial eligibility criteria (income under 400% of FPL and assets under $6,000 excluding one car and one house), have applied and be eligible for public or other disability programs, be medically disabled as a result of HIV/AIDS, and have a health insurance plan that covers outpatient prescription drugs and HIV-related treatment services. Enrollment services are provided through 148 participating agencies in all counties except Alpine, Amador, Glen, Modoc, and Sierra. CARE/HIPP pays providers an administrative fee for each client they enroll in the program. Eligible individuals can be enrolled, re-certified, and assisted in the transition process through any participating agency.

CARE/HIPP program coverage is a maximum of 29 months per client. Clients must reapply for coverage annually and meet eligibility criteria in order to continue program coverage.

A recent OA cost-to-benefit study estimates that for every $1 spent by CARE/HIPP, $7.56 in government expenditures on care for the medically indigent is saved.

Local HIV Care Consortia and Direct Services Program

The Title II-funded HIV Care Consortia and Direct Services Programs provide funding to local agencies for the provision of medical and support services for persons living with HIV/AIDS. Recommendations for developing service delivery plans and strategies are provided by local planning bodies such as HIV Care Consortia, Title I Planning Councils, and local advisory groups. These planning bodies consist of persons living with HIV/AIDS, interested parties, public and private non-profit health care and support service providers, and representatives of various public health, housing, and community-based organizations.

Planning bodies are responsible for conducting or updating an assessment of HIV/AIDS service needs for their geographic services area, establishing a service delivery plan based upon prioritized services, coordinating and integrating the delivery of HIV-related services, evaluating the success in responding to service needs, and evaluating the cost-effectiveness of the mechanism used to deliver comprehensive care.

Funds are made available to all 58 counties in California and are available to provide primary medical care and a range of services that will provide access to primary medical care. These services include ambulatory/outpatient medical care, case management, dental care, drug reimbursement, health insurance, home health care, mental health therapy, nutritional services, substance abuse treatment/counseling, and other services of a treatment nature.

Housing Services

Housing Opportunities for Persons with AIDS (HOPWA)

The U.S. Department of Housing and Urban Development (HUD) provides funding for housing and supportive services for low-income people living with HIV/AIDS through the HOPWA Program. This program's objective is to prevent or alleviate homelessness among people living with HIV/AIDS and their families.

HOPWA funding allocations are distributed by HUD to Eligible Metropolitan Statistical Areas (EMSAs) and eligible state grantees. The California counties included in EMSAs and receiving direct HOPWA funding from HUD are Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, Sacramento (including El Dorado and Placer), San Bernardino, San Diego, San Francisco, San Mateo, and Santa Clara.

The OA, as the State Grantee for HOPWA funds, receives funds on behalf of the 44 non-EMSA counties. In FY 2000/01, the HOPWA allocation was $2.489 million, which provided affordable HIV housing and supportive services to 4,127 eligible clients and families.

HOPWA funds may be used to provide various types of housing assistance designed to prevent or alleviate homelessness. Eligible uses of HOPWA funds include providing short and long-term rental, utility and mortgage assistance; developing housing units through new construction; or acquiring and/or rehabilitating affordable housing units designated for persons living with HIV/AIDS. Additionally, HOPWA funds are available to provide supportive services required to prevent homelessness. All residents of HOPWA-assisted units must have access to supportive HIV services.

HIV Housing Program

While HOPWA funds have historically assisted clients with short-term rental assistance, the OA recognized that there was an unmet need for long-term housing resources for persons living with HIV/AIDS.

To promote the development of affordable long-term housing options for persons living with HIV/AIDS, the OA established the Competitive HIV Housing Development Program in 1997. This program is funded jointly through the state General Fund and HOPWA. Funding is awarded annually on a competitive basis to nonprofit housing providers, local governments, and HIV/AIDS service providers working collaboratively to develop HIV-designated housing units within the 11 counties (excluding EMSAs) with the highest need for affordable HIV/AIDS housing.

Since its inception in 1997, the HIV Housing Program has developed a total of 68 affordable HIV/AIDS housing units statewide.

Four housing projects were funded in FY 2001, which added an additional 16 affordable housing units to the 52 previously developed as a result of the HIV Housing Program. These units are designated for persons living with HIV/AIDS and their families, and will provide affordable, stable housing for many years to come. The success of this program is due to the collaborative efforts of HIV service agencies and housing agencies.

Since its inception in 1997, the HIV Housing Program has developed a total of 68 affordable HIV/AIDS housing units statewide.

Residential AIDS Licensed Facilities Program

The Residential AIDS Licensed Facilities (RALF) Program was enacted through the Budget Act of FY 1999/00 and

receives an annual $1 million allocation of state General Funds. This program is designed to provide direct subsidy payments to residential AIDS facilities licensed under the Residential Care for the Chronically Ill (RCFCI) licensing category. RCFCIs are the only facilities licensed by the Department of Social Services that California law permits to accept and retain adults with HIV/AIDS in need of a high level of care. There are currently 28 licensed RCFCIs in California with a total capacity of 409 beds.

The RALF Program provides operating funds based upon the total number of beds designated for persons living with AIDS. In FY 2001, the RALF Program provided assistance to 24 RCFCI facilities ensuring that 303 beds, or 110,595 bed nights, continued to be designated for persons living with AIDS.

AIDS Case Management Program

The AIDS Case Management Program (CMP) provides comprehensive, cost effective, home- and community-based services for persons with AIDS or symptomatic HIV infection who are unable to function independently. The program maintains clients safely in their homes and avoids the need for more costly institutional care in a nursing facility or hospital. The OA contracts with 42 LHJs and community-based organizations to administer the program in 53 counties.

In FY 2001/02, the CMP received a total of $8.6 million ($6.7 million in state funds and $1.9 million in federal Ryan White CARE Act Title II funds). Of the $8.6 million, $300,000 in state General Funds was allocated to San Francisco, Alameda, Los Angeles, and Monterey Counties specifically for services to people of color. In FY 2001/02, a total of 1,314 client slots were allocated statewide.

An interdisciplinary core case management team consisting of a nurse case manager (NCM), social worker case manager (SWCM), and an attending physician coordinate client care, with the participation of the client and/or a legal representative. The NCM and SWCM conduct ongoing client assessments, develop and implement a service plan to meet the client's needs, and coordinate the provision of cost-effective, quality services to the client. When appropriate, benefits counselors and case aides provide practical arrangements for meeting the client's non-health related needs.

Services include case management, and may include attendant care, homemaker services, in-home skilled nursing, nutritional counseling and supplements, benefits and psychosocial counseling, transportation and housing assistance, food subsidies, and durable medical equipment and supplies. The CMP is the payor of last resort, and maximizes the use of third-party financial participation and other funding sources.

To be eligible for the CMP, adult clients must be scored at 70 or less on the Cognitive and Functional Ability Scale, which includes factors affecting abilities that are specific for adults with HIV infection. Children under the age of 13 at any stage of HIV infection are eligible for CMP.

Most CMP contractors also contract with the AIDS Medi-Cal Waiver Program (MCWP). The co-existence of these programs in the same agency allows CMP clients to transition to AIDS MCWP services as needed, without an interruption of services and care providers.

AIDS Medi-Cal Waiver Program

The AIDS MCWP provides comprehensive, cost effective, home- and community-based services to Medi-Cal beneficiaries with mid-to-late stage HIV/AIDS. Like the CMP, the MCWP maintains clients safely in their homes and avoids more costly institutional care in a nursing facility or hospital. The OA currently contracts with 36 county health departments and community-based organizations to administer the program at the local level in 48 counties. These agencies subcontract with qualified providers for direct care.

In general, MCWP clients tend to be more frail than those in the CMP. MCWP clients must be certified as needing nursing facility level of care or above, be a Medi-Cal recipient, not be enrolled in CMP or Medi-Cal hospice, and have exhausted other coverage similar to that available under the MCWP before use of MCWP services.

To be eligible for MCWP, adult clients must be scored at 60 or less on the Cognitive and Functional Ability Scale. Children must be classified as A, B, or C on the *"Centers for Disease Control and Prevention Classification System for HIV Infection in Children Less than 13 Years of Age,"* as well as meeting the nursing facility level of care to be eligible for MCWP.

Care & Treatment

Like the CMP, client care for the MCWP is coordinated through an interdisciplinary core case management team. Authorized services include case management, and may include in-home skilled nursing, attendant care, homemaker services, psychosocial counseling, nutritional counseling and supplements, minor physical adaptations to the home, transportation, medical equipment and supplies, and financial assistance for infants and children in foster care.

In calendar year 2001, the MCWP served 2,831 unduplicated clients and expended an estimated $12.7 million for client services and administrative fees.

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Education & Prevention

The OA collaborates with LHJs, community-based organizations, service providers, advocacy organizations, universities, and other state and federal agencies to develop and implement focused HIV education and prevention programs. The primary goals of these programs are to prevent HIV transmission; change individual attitudes about HIV and risk behaviors; promote the development of risk-reduction skills; and change community norms that may sanction unsafe sexual and drug-taking behaviors.

Statewide Community Planning Process

In 2001, the CHPG was restructured to address education and prevention issues statewide. Care services issues, previously addressed by the CHPG, became part of a new comprehensive planning process that the HIV Care Branch initiated in 2001 (see the Care and Treatment chapter of this report for more information). The CHPG is composed of people living with HIV/AIDS, community advocates, public health officials, and representatives from communities of color. In 2001, CHPG formed task forces to focus on the following areas: rapid HIV testing, hepatitis C, prevention for positives, MSM, resource allocation, and the draft *California HIV Prevention Plan.* The draft Plan will be used as a blueprint for implementing local and prevention programs. In collaboration with the UARP and the OA, the CHPG focused evaluation efforts on support for community planning at the local level.

Local HIV Prevention Community Planning

Local Implementation Groups, composed of advocates from the communities served, representatives from community-based organizations, and LHJ staff, have strengthened the partnership and collaboration between the public and private HIV/AIDS sectors. Each planning group has developed a local HIV prevention plan for implementing local HIV education and prevention programs. OA staff provides technical assistance, guidance, and timelines for implementing and assessing the HIV prevention plans and measuring the progress of local planning groups. Local planning groups also generate the data on which education and prevention program funding decisions are based at the local level.

HIV Education and Prevention Program Funding

Based on priorities identified in the draft statewide *California HIV Prevention Plan* and HIV Prevention Community Plans, the OA allocated HIV education and prevention funds to all 61 LHJs in California. Of the 61 LHJs, five northern California counties have formed two separate local implementation groups. Local implementation groups are composed of representatives from LHJs, community-based organizations, and affected or HIV-infected members of the community they serve. The following target populations were identified for local community planning: substance users and their sex partners, gay and bisexual men of all ages and ethnicities, sex industry workers, youth and adolescents, people of color, and transgender individuals.

In FY 2001/02, budget constraints resulted in a $2 million reduction in funding for this program, decreasing the total program allocation to $18 million. Subsequently, each local health jurisdiction received a 10% reduction to their annual allocation.

California AIDS Prevention Campaign

The California AIDS Prevention Campaign, the HIV prevention multicultural public information campaign of the OA, supports the work of the Education and Prevention Services Branch, and complements local and national HIV prevention efforts. Similar to previous years, the campaign's focus was to encourage sexually active adolescents and young adults to adopt safer sex behaviors and encourage individuals at greatest risk for contracting HIV (men who have sex with men [MSM] and their female partners, and IDUs and their partners) to seek HIV counseling and testing.

Building upon previous successful public relations and community marketing activities, the 2001 campaign introduced several new HIV prevention strategies. The campaign continues to raise awareness of HIV/AIDS prevention issues in California and is designed to be responsive to the needs of multi-ethnic audiences, particularly African American and Latino communities where HIV infection rates are disproportionately high. The campaign uses a peer education approach featuring Californians affected by HIV/AIDS delivering personal messages about HIV prevention. To enhance the effect of media, messages and outreach materials incorporate the state-funded multi-language California AIDS Hotline number (1-800-367-AIDS). Highlights of the California AIDS Prevention Campaign for 2001 include:

African American Church Outreach Program

In its second year, the African American Church Outreach program featured the launch of the revised and updated

Healing Begins Here: A Pastor's Guidebook for HIV/AIDS Ministry through the Church. The new version of the guidebook included updated information about the impact of HIV and AIDS on the African American community, suggestions and biblical references for incorporating compassion and prevention messages into sermons and ministries, testimonials of African Americans living with AIDS, and new supplements that address the HIV testing process as well as information to help churches begin or enhance AIDS ministries. All materials were developed in collaboration with the statewide church advisory board to ensure acceptability in the church environment.

Through December 2001, *Healing Begins Here* was distributed to nearly 3,000 religious and public health leaders, reflecting the efforts of a partnership between the OA and African American Church leaders from across the state. In June 2001, the guidebook was introduced in Northern California through a ministry training program sponsored by Ark of Refuge Ministries. The program and guidebook have received statewide, national, and international media attention, as well as national recognition, receiving an Association of State and Territorial Health Officers Vision Award in 2001. To ensure the widest possible access, the guidebook is posted on several websites including the Multicultural AIDS Resource Center of California website at http:www.marcconline.org and the Ark of Refuge website at http:www.arkofrefuge.org.

In 2001, *Healing Begins Here* garnered national recognition as a recipient of an Association of State and Territorial Health Officers Vision Award.

Additionally in 2001, in support of the guidebook, the OA developed a companion "quiz card" outreach tool for distribution to church members to encourage discussion of HIV prevention. The OA will complete follow-up evaluations for the program in 2002.

Spanish Language HIV Prevention Fotonovela

The OA developed a new Spanish language fotonovela to help spark a dialogue and provide much needed information for people in the Latino community who are at risk for HIV infection. Fotonovelas have been identified as useful intervention tools to reach the broader Latino community, including non-gay identified MSM. Targeting sexually active young Latinos ages 18-34, this fotonovela was developed via a thorough research and community review process and reflects the messages and images identified by community members to best address HIV awareness and prevention needs. Over 230,000 copies of the fotonovela were distributed in August 2001 as an insert in five Spanish language newspapers across California, including La Opinión, the largest Spanish language newspaper in the country. In addition, 20,000 overruns were made available through the California AIDS Clearinghouse for AIDS service organizations serving Latino community members.

Latino HIV Prevention Lowrider Campaign

The Lowrider Campaign targeting at-risk Latino youth was launched in April 2000 and continued through June 2001. The campaign featured a restored and customized 1953 Chevy Bel Air that served as a "moving billboard," painted with original artwork and HIV prevention messages in English and Spanish. A Modesto-based lowrider group donated the use of the vehicle, provided oversight for its restoration, and was instrumental in securing donations for many of the accessories. In 2001, the car traveled to three cultural events targeting Latinos in Northern, Southern, and Central California. Over 700,000 people attended the three events, potentially reaching tens of thousands of Latinos at risk for HIV infection. Local community-based AIDS service organizations were invited to provide outreach and educational services in conjunction with each event, promoting HIV prevention messages in English and Spanish.

"Rap It Up" Safer Sex Rap Writing Contest and Radio Promotion

For the third year, the OA worked with radio stations and retailers in two major urban markets in California to construct an innovative radio promotion. The promotion was designed

to raise awareness and acceptability of condom use, and encourage listeners to call the California AIDS Hotline for more information about safer sex and HIV counseling and testing. The spring/summer 2001 promotion targeted sexually active adolescents and young adults ages 15-25, particularly African American and Latino youth.

The promotion capitalized on the disc jockey's credibility as a prevention messenger, and offered opportunities for radio listeners to enter a safer sex rap writing contest for prizes ranging from a studio recording opportunity to cash prizes of up to $1,000. The 2001 promotion delivered more than 12 million gross impressions, effectively reaching large numbers of at-risk African American and Latino youth. Nearly 400 rap entries were received. The promotion also collaborated with a retail music partner that had over 150 outlets in both Northern and Southern California. In addition, the promotion included radio spots, live remotes, appearances at summer concerts and festivals, website hyperlinks, in-studio interviews, public service announcements, and promotional merchandise. The OA received over $7.00 in value for every dollar of purchased on-air radio time.

HIV Prevention Calling Card Campaign

The HIV Prevention Calling Card Campaign, targeting individuals at greatest risk for contracting HIV, was significantly expanded in 2001. In response to program evaluations, the OA produced a new bilingual English/Spanish card targeting youth with artwork and messages designed, selected, and focus tested with youth at several youth drop-in centers. Initially, 12,000 cards were distributed to 11 youth drop-in center programs across the state. Additionally, several hundred thousand new cards were distributed to over 125 LHJs or community-based organizations in California for use as outreach and incentive tools for HIV prevention, education, and counseling and testing services. The cards were produced in four designs with empowering messages such as "Respect Yourself, Protect Yourself" and on the bilingual Spanish/English card, "Tu Vida Cuenta" ("Your Life Matters"). Prior to accessing calling time, calling card users hear one of several 15-second HIV/AIDS prevention messages.

Additional Media Activities

Other public and media relations activities included promoting OA programs and services utilizing milestone events such as the 20th Anniversary of AIDS in June 2001, World AIDS Day, and National HIV Testing Day; community marketing materials including lottery style educational scratcher and outreach cards, counter displays, posters; and technical assistance to LHJs and community-based organizations in social marketing and media relations.

Local HIV Prevention Social Marketing Efforts

The use of social marketing provides an effective planning tool for implementing and evaluating interventions created and tested for a specific target audience. In 2001, funding was continued for seven LHJs participating in a three-year social marketing campaign. As part of the campaign, each LHJ implemented an integrated set of HIV prevention activities targeting high-risk populations to reach specific behavioral goals. The primary strategies defined in localized social marketing plans include outreach, workshops, coalition building, community mobilization, media advocacy, public relations, advertising, and materials development. This approach follows the trend of local community planning and outreach efforts that emphasize targeted local strategies for high-risk individuals, and adds flexibility to develop specific products and/or services to reach those at greatest risk for contracting HIV.

HIV Counseling and Testing Program

The HIV Counseling and Testing Program provides anonymous and/or confidential HIV counseling and testing services to Californians with perceived risk for HIV. In FY 2001/02, the HIV Counseling and Testing Program provided approximately $8 million in state and federal funds to 61 LHJs, rural primary care clinics, and Indian health clinics.

Both anonymous and confidential HIV counseling and testing services provide client-focused prevention counseling and assessment of client needs regarding:

- HIV transmission;
- Personal risk behaviors;
- Risk-reduction planning; and
- Referral to other services.

Risk information collected during the counseling session is used as a basis for data collection, program development, and program reimbursement. Client counseling and testing services are voluntary and free to clients.

Rapid Testing

A rapid test for detecting HIV antibodies is a screening test that produces very quick results, usually in less than 30 minutes. In comparison, results from enzyme immunoassays currently used for HIV screening often are not available for one to two weeks. Algorithms of two or more rapid tests that have a combined sensitivity and specificity comparable to our current standard, may enable health care providers to supply definitive negative and confirmed positive results to patients at the time of testing. This could increase the overall effectiveness of counseling and testing by increasing the number of clients who receive their test results. In 2000, the OA was awarded a three-year grant from the CDC to conduct operations research on rapid testing for HIV in minority populations. The project will involve collaboration with several LHJs that serve high-risk clients in California. Goals of the research include:

- Developing, implementing, and evaluating protocols for the delivery of HIV services in a rapid-testing environment;
- Investigating differences between return rates, testing rates, and effectiveness of counseling strategies under rapid testing versus standard testing protocols; and
- Evaluating client, counselor, and administrator reactions to new protocols.

In 2001, following legislative action that removed barriers to implementing rapid testing, the OA finalized project protocols and submitted them to appropriate institutional review boards. Implementation of the rapid testing research at designated sites will begin following approvals from the necessary review boards. Results from this project will help determine the potential for implementing rapid testing and counseling services throughout California.

HIV Post-Exposure Prophylaxis

In response to statewide disparities in sexual assault services, the OA, in collaboration with the San Francisco Department of Public Health, developed HIV post-exposure prophylaxis (PEP) guidelines for California. These guidelines provide information and support to providers of sexual assault treatment so that HIV PEP can be integrated into the medical care offered to sexual assault survivors uniformly throughout the state. This development process included surveying each county to determine the local policy on PEP after sexual assault; reviewing data on the rate of HIV among convicted sex offenders; conducting a literature and research review related to HIV PEP after occupational or non-occupational exposure; and convening a panel of experts knowledgeable about the issues involved in PEP after sexual assault to formulate appropriate guidelines.

In 2001, the *Offering HIV Prophylaxis Following Sexual Assault - Recommendations for the State of California* were distributed to county health officers, county HIV/AIDS directors, members of the PEP advisory panel, and all California county post-sexual assault treatment providers/hospitals.The guidelines are also available on the OA website at http:www.dhs.ca.gov/aids/Reports/SexualAssault/.

Community Health Outreach Worker Training

The OA contracts with the Institute for Community Health Outreach (ICHO) to train community health outreach workers (CHOWs) for OA education and prevention contractors. CHOWs provide health education services to high-risk populations such as IDUs, their sexual partners, and high-risk youth. The ICHO training methods have become an international model for outreach intervention.

To meet community needs, the ICHO continually expands the scope of its training, developing innovative health education strategies for outreach to MSM, women of childbearing age, sex industry workers, injection and non-injection drug users, runaways, gang members, the homeless, migrant workers, transgender individuals, and communities of color. All ICHO trainings emphasize multi-cultural competence in serving clients of different sexual orientations and racial/ethnic origins. Training is also offered for experienced CHOWs and for supervisors and administrators of outreach programs.

HIV Prevention Counselor Training

The goal of the HIV Prevention Counselor Training program is to ensure a uniform, high standard of service at all OA-funded HIV counseling and testing sites. The training curriculum helps prevention counselors gain the necessary skills to provide consistent assessment, effective intervention, and appropriate referral services for at-risk clients. The HIV Prevention Counselor Training is a seven-day course delivered in two separate trainings, Basic I and Basic II.

The Basic I is a five-day training that includes an introduction to client-centered counseling skills relating to risk assessment, risk reduction, counseling guidelines, and cultural issues. Basic HIV/AIDS information, California AIDS laws, HIV testing procedures, and HIV epidemiology are also included. The Basic II is a two-day training that focuses on enhancing client risk assessment skills and emphasizes behavior change models, risk reduction planning, and secondary risk factors for HIV infection (e.g., social, cultural, economic, psychological).

Successful completion of both trainings authorizes an HIV Prevention Counselor to provide HIV prevention counseling services. All counselors annually participate in Continuing Education Training (CET) in order to maintain eligibility as an HIV Prevention Counselor. The one-day CET class addresses various topics designed to enhance specific skills of experienced counselors.

Outreach to High-Risk Groups

The Neighborhood Interventions Geared to High-Risk Testing (NIGHT) Outreach program provides services in 21 LHJs and targets individuals at highest risk for contracting HIV. Outreach services are provided to at-risk populations in venues where they congregate (e.g., streets, bars, parks, homeless shelters) and outreach staff are typically former members of the at-risk population. Street outreach workers use one-on-one interaction to establish rapport, with the goal of increasing HIV counseling, testing, and referrals for social services and follow-up services.

Mobile HIV testing clinics are used in seven of the LHJs to facilitate testing in street outreach venues, primarily in areas where there is rapid emergence of new HIV outbreaks. These large mobile health clinics also offer STD and TB screenings. Twelve other LHJs use smaller vans for HIV counseling in outreach settings. The smaller vans provide a safe, private, confidential setting where counseling can occur.

The OA, HIV Prevention Research and Evaluation Section is currently evaluating the NIGHT program. This evaluation will include both process and behavioral outcome measures to assess program effectiveness.

Prevention of Perinatal Transmission of HIV Project

The HIV Education and Prevention Services Branch, in collaboration with the HIV/AIDS Epidemiology Branch and Stanford University, has developed a perinatal project to increase the level of HIV education, counseling, and testing offered to pregnant women in California. In order to develop and assess an array of sociodemographically-diverse interventions, the state- and federally-funded project will involve a two-tiered strategy of needs assessment, followed by targeted perinatal services. Perinatal prevention assessment and services will be targeted to five California counties (Alameda, Los Angeles, Sacramento, San Diego, and San Joaquin) that are composed of diverse socioeconomic and racial and ethnic populations.

The project will identify populations with access to care issues, develop cultural and socially appropriate interventions, and disseminate and evaluate these interventions. It will primarily be integrated into existing population-based active surveillance. The project will include focus groups and surveys of women who attend state-funded nutritional supplementation clinics, women in correctional facilities, female clients of substance abuse treatment centers, women in alternative high school educational programs, and prenatal care providers. Materials developed will be designed to enhance the efforts of health and service providers to achieve the goal of offering HIV counseling and voluntary testing to all pregnant women. Local activities will be accomplished through program outreach staff.

High-Risk Initiatives

In 2001, the OA continued second year funding for the three-year High-Risk Initiative targeting four populations: MSM, women, people of color, and high-risk youth. Initial awards were made to numerous counties throughout the state in 2000. Upon completion of the three-year Initiative, all projects will be evaluated by the OA in collaboration with the UARP. The High-Risk Initiative is unique in its support of collaboration between researchers and county health departments on the design and implementation of prevention evaluation research, ensuring scientifically sound evaluations that are applicable in community settings. Details of each Initiative are as follows:

Men Who Have Sex With Men

MSM still account for the majority of AIDS cases statewide, with an increase in reported cases among African Americans and Latinos. A general shift away from “safer sex” practices has been reported among HIV-infected MSM. In 2001 the OA continued funding 11 jurisdictions (Alameda, Berkeley, Butte, Fresno, Long Beach, Los Angeles, Orange, San Diego, Santa Clara, Solano, and Sonoma) for projects serving

high-risk MSM. These projects primarily target MSM of color who are HIV-negative or HIV serostatus unknown and are at high risk for contracting HIV. Group level clinical interventions will help MSM evaluate their personal risk for HIV infection, generate group norms supportive of safer behaviors, and provide information, skills, and feedback on behavior outcomes. Clinical interventions in each jurisdiction are delivered in small group sessions in a variety of settings including health care establishments, worksites, and drug treatment centers.

Women and People of Color

People of color and women, especially women of color, are among the fastest growing populations of people with AIDS in California. This initiative sought qualified LHJs to work with community-based organizations to develop, expand, and implement HIV primary prevention interventions for women and people of color at high risk for HIV infection. In 2001, with state funding, the OA continued grants to Humboldt, Orange, San Diego, and Santa Clara Counties for projects that target high-risk women and their sex and needle-sharing partners. High-risk People of Color Projects, funded in 2001, include the City of Berkeley and the counties of Alameda, Sacramento, and Sonoma.

Funds totaling $1,925,000 annually were awarded to select counties to provide prevention services in a private and comfortable setting for low-income youth who are at high-risk for HIV infection.

Additional federal funding received from the CDC continued the funding of eight additional jurisdictions: Alameda, Imperial, San Luis Obispo Counties (women's projects), Humboldt, Santa Clara, San Diego, San Joaquin, and San Luis Obispo Counties (people of color projects).

Youth

The counties of Fresno, Humboldt, Imperial, Mendocino, Orange, San Diego, San Luis Obispo, Santa Clara, Santa Cruz, and Shasta were funded to operate youth drop-in centers at 15 locations. A drop-in center is a small, storefront-style building located on an active pedestrian thoroughfare, near public transportation. Its purpose is to provide prevention services in a private and comfortable setting to low-income youth at high risk for HIV infection. A drop-in center is a neutral space where positive health maintenance is the primary objective.

Each county health department collaborates with at least one community-based organization with the capacity and programmatic expertise to provide risk reduction and prevention services to high-risk youth between the ages of 12 and 24. The OA provides technical assistance to these projects and facilitates collaboration between the counties.

Partner Counseling and Referral Services (PCRS)

The OA PCRS program has been fully implemented since FY 1998/99. Through this program, PCRS counselors help clients learn how to disclose their HIV status to their partners in a productive and sensitive manner and teach clients how to encourage their partners to seek HIV counseling, testing, and PCRS services.

The OA contracts with the STD/HIV Prevention Training Center to provide PCRS training to local STD and HIV prevention staff. In 2001, a total of 11 two- and three-day PCRS trainings were given to 122 HIV and STD program staff, case managers, and nurses. The PCRS trainers provide technical assistance, conduct site visits with state consultants, and contact training participants after the course to enhance the training experience.

The PCRS program is available in 12 LHJs. During calendar year 2001, a total of 515 HIV-positive clients were offered PCRS. Data analysis from these sessions showed that:

- Clients accepting PCRS designated a total of 173 partners for services. The average number of partners designated per client was 1.2 and ranged from 0 to 15, with a majority (77%) designating only one partner for PCRS;

- Approximately 29% of clients chose to access PCRS while another 44% were willing to consider the services;
- Approximately 35% of partner notifications were conducted by the PCRS counselor singularly or in conjunction with the client; and
- Over half of the located partners (n=23) chose to be tested through PCRS and 17% were determined to be HIV infected, learning of their HIV-positive status for the first time; six already knew they were HIV-positive; three indicated that they had recently received counseling and testing; and two chose not to test.

Corrections Initiative

In 2001, the OA continued funding for a cooperative agreement program for HIV prevention, intervention, and continuity of care within correctional settings and the community. The Corrections Initiative, implemented in 1999, supports demonstration projects that develop models of comprehensive surveillance, prevention, and health care activities for HIV, STDs, TB, substance abuse, and hepatitis. The Initiative focuses on transitional links for pre- and post-release HIV-positive inmates. The goals of the project are to:

- Promote awareness of HIV/STD/TB/hepatitis risk and utilization of HIV testing, STD/TB/hepatitis screening, and appropriate treatment;
- Initiate and sustain positive behavior change for pre- and post-release inmates with high-risk behaviors related to substance abuse and/or the transmission of HIV/STD/TB/hepatitis;
- Improve the health status of the target population by providing comprehensive educational and psychosocial services aimed at increasing access and use of HIV treatment therapies;
- Provide an intensive training program for service providers to ensure the provision of appropriate behavioral and clinical assessment, care, and evaluation;
- Improve the utilization of community health services by improving the transitional linkages between correctional facilities and community-based care;
- Continue behavioral, epidemiologic, and surveillance activities associated with the target population; and
- Reduce recidivism among the target populations.

The Corrections Initiative is a collaborative of the OA; the City and County of San Francisco; Los Angeles County; the California Department of Corrections Peer Education, Parole and Transitional Case Management programs; the California STD/HIV Prevention Training Center; and Centerforce (a community-based organization).

In 2001, services were provided to local jail facilities in the City and County of San Francisco. The San Francisco program is a collaboration with Continuum HIV Day Services, Haight Ashbury Free Medical Clinics, Forensic AIDS Project, and the UCSF Positive Health Program. The San Francisco program provides HIV-infected, high-risk HIV-negative, and unknown serostatus inmates with transitional case management, peer advocacy, and substance use counseling. Upon their release, they are provided with money management, housing services, and HIV/STD prevention services.

In Los Angles County, the Office of AIDS Programs and Policy coordinates its efforts with the Los Angeles County Sheriff's Department and three community-based organizations: Tarzana Treatment Center, Minority AIDS Project, and JWCH, Inc. The Los Angeles Project provides a continuum of care through pre/post release transitional case management, including linkages to medical services and other social support (i.e., mental health, substance abuse, housing, public benefits) for HIV-positive inmates who are making a transition back to their communities.

Centerforce works collaboratively with the California Department of Corrections Peer Education, Parole and Transitional Case Management programs to provide peer education, pre-release health education, and prevention case management for high-risk HIV-negative clients. Centerforce is currently organized in two state prisons: San Quentin and Central California Women's Facility at Chowchilla. Other state prisons are being evaluated as possible project sites.

Additionally in 2001, the OA was awarded federal funding to implement hepatitis B (HBV) and hepatitis C (HCV) screening and vaccination for this project in the San Francisco County jails. The project targets adults incarcerated in San Francisco jails who are at risk for HIV (those testing negative for HIV or not knowing their status) and/or viral hepatitis infection. Over 50,000 (30,000 unduplicated) arrestees

Epidemiology

Epidemiologic research helps public health officials monitor and project the extent of the HIV/AIDS epidemic in California. The OA, in collaboration with LHJs, community-based organizations, universities, and other state organizations, conducts a variety of epidemiologic studies that are funded by both the state and federal government. Epidemiologic data help guide resource allocation and program strategies for HIV/AIDS education, prevention, and care and treatment. Only AIDS cases were reportable in California in 2001, which limited our knowledge of the true burden of the HIV/AIDS epidemic. To provide a more complete understanding of the epidemic in our state, in 2001 the OA released draft regulations for a non-name code HIV reporting system, with implementation expected in July 2002.

HIV/AIDS Case Registry

The OA maintains the HIV/AIDS Case Registry, a confidential, central registry of demographic and clinical information on all reported California AIDS cases. Communicable disease personnel assigned to the Registry routinely collect these data from LHJs throughout the state. AIDS data are stored in a computer database secured and isolated from outside contact, and paper files are in locked cabinets within a secured area. The records are analyzed, stripped of identifiers, and forwarded to the CDC for use in the national statistics. Encryption programs and a secure work environment ensure the confidentiality of the Registry's case information.

The Registry provides LHJs with support and training for developing, maintaining, and enhancing surveillance programs. Additionally, the OA provides large LHJs with a computer containing the HIV/AIDS Reporting System software and appropriate security software, for monitoring of the epidemic within their jurisdictions.

HIV Reporting

California has the second largest number of reported AIDS cases in the nation, yet the incidence of HIV infection, the precursor to AIDS, remains unknown because HIV infection without an AIDS diagnosis was not reportable in California in 2001. The Budget Act of Fiscal Year (FY) 2000/01 provided $2.8 million to the OA for developing and implementing a non-name code HIV reporting system. Over $1.4 million of this funding was allocated in FYs 2000/01 and 2001/02 to LHJs to begin preparations for HIV reporting.

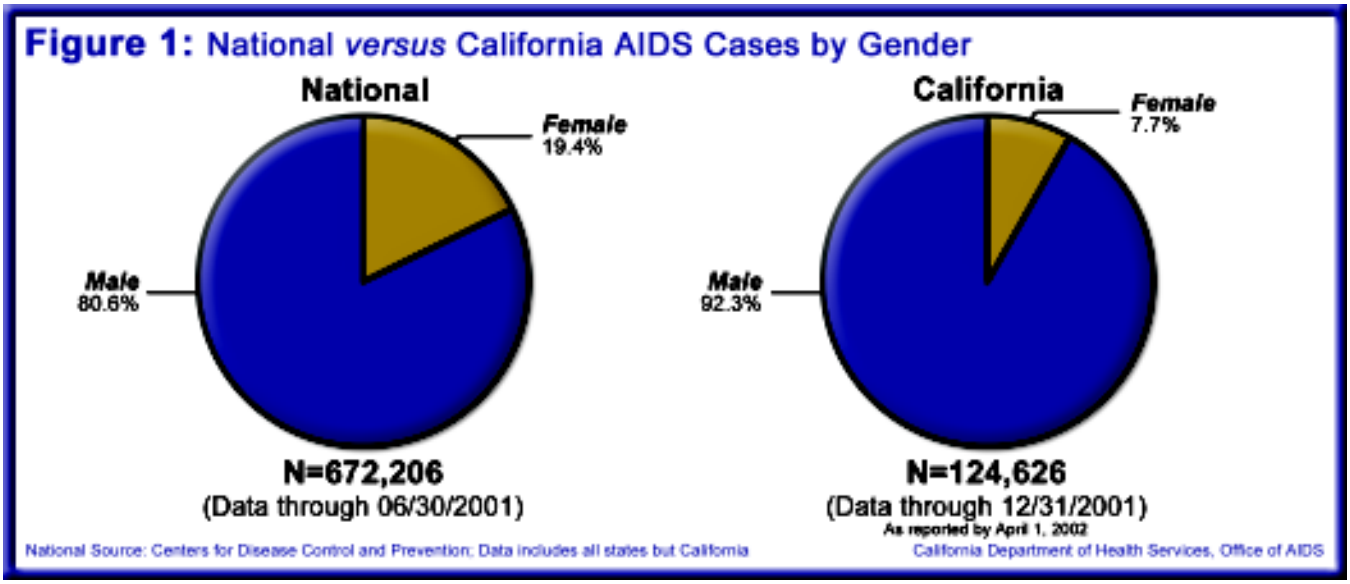
Development of California's HIV reporting regulations began in 2000. During 2001, the proposed regulations were released for two separate public comment periods, one in March and the second in December. Revisions to the proposed regulations were made based on analysis of public comments received during these periods. The final version of the proposed regulations will be submitted to the Office of Administrative Law for approval in early 2002. Implementation of HIV reporting is targeted for July 2002.

The proposed system will report HIV infection using a non-name code composed of a number of elements used together to establish 'uniqueness' while not readily identifying the HIV-infected individual. HIV case report data will be securely stored in the HIV/AIDS Case Registry in a manner similar to AIDS case reports. Reporting HIV infection in addition to AIDS case data will allow the State to better monitor the progress of the epidemic and to more effectively target prevention, education, and care resources to affected populations.

Additionally, during 2001, several pre-implementation activities were begun, including development of a Request For Proposals for a contract to develop and provide an HIV reporting regulations training curriculum targeting laboratories, health care providers, and HIV/AIDS surveillance staff at LHJs.

AIDS Case Trends

As of December 31, 2001, California had a cumulative total of 124,626 reported AIDS cases. Of these, 75,681 had died, for a case fatality rate of 60.7%. Since the first case of AIDS was reported in 1981, the risk groups and populations most affected by the epidemic have shifted. Early in the epidemic, White MSM represented the majority of AIDS cases in California. Recent data indicate that although the majority of AIDS cases reported each year are attributable to MSM, the proportion of new AIDS cases among people of color, injection drug users (IDUs), and their sex partners, are increasing.



California AIDS Data Compared with National Data

- For AIDS cases reported through July 1, 2001, (the latest data available for national AIDS cases), California accounts for approximately 13.4% of all presumed living AIDS cases in the United States and Puerto Rico (data not presented).
- The AIDS epidemic in California continues to be predominately among men. The proportion of cumulative AIDS cases among women in California is smaller (7.7%) than that for the United States (19.4%) (Fig. 1).
- The age distribution of persons diagnosed with AIDS in California is similar to that of the nation, with most cases among 30-39 year olds (Fig. 2).

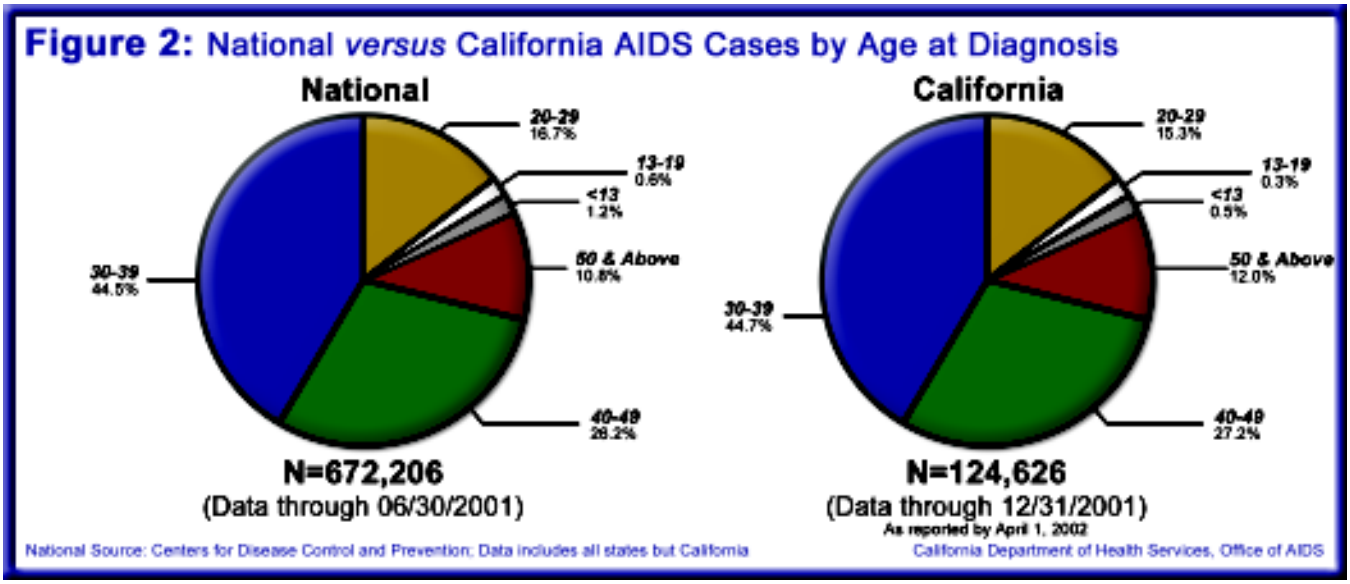
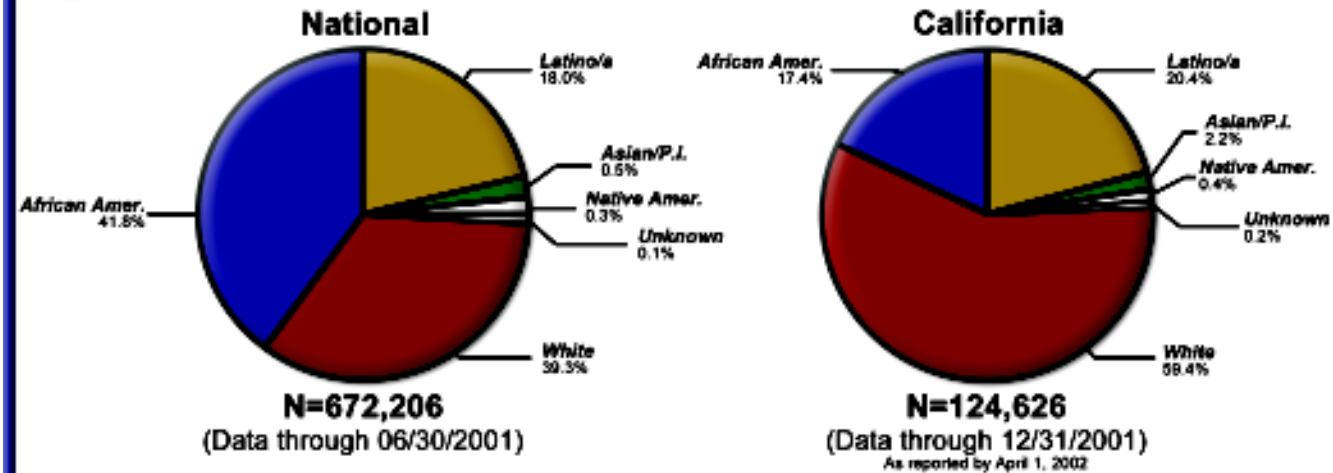


Figure 3: National *versus* California AIDS Cases by Race/Ethnicity



National Source: Centers for Disease Control and Prevention; Data includes all states but California

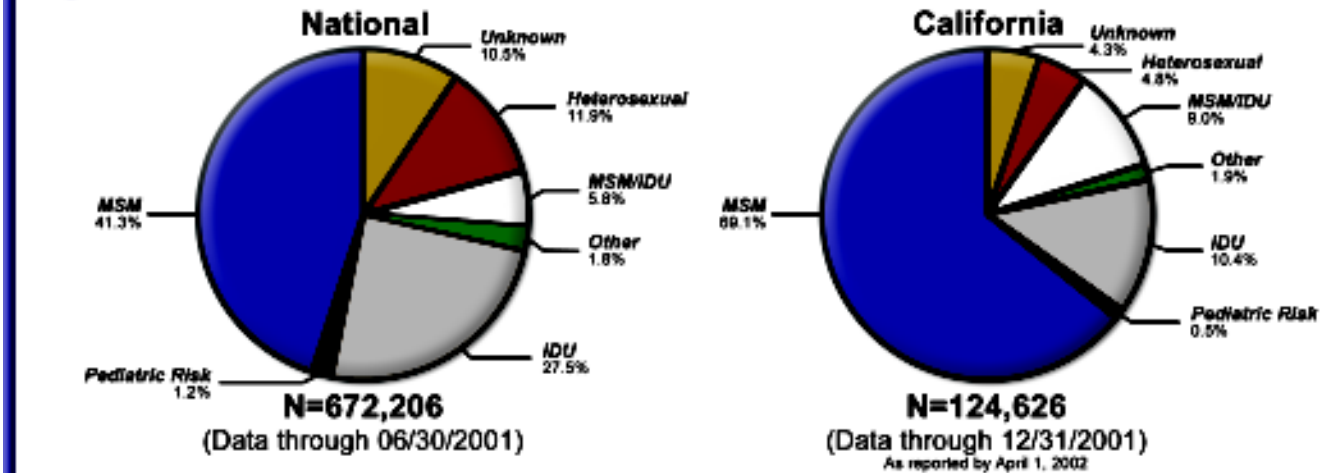
California Department of Health Services, Office of AIDS

- California, compared with the rest of the nation, has a larger proportion of cumulative AIDS cases occurring among Whites (59.4% versus 39.3%, respectively). While proportions also vary for Latinos (20.4% versus 18%), Asian/Pacific Islanders (2.2% versus 0.5%) and African Americans (17.4% versus 41.8%) (Fig. 3), these differences more closely reflect the racial-ethnic variations found in the general populations of California and the nation.

- Approximately 78% of cumulative AIDS cases reported in California are attributed to sex between men (MSM and MSM/IDU) compared with just over 47% nationally (Fig. 4).

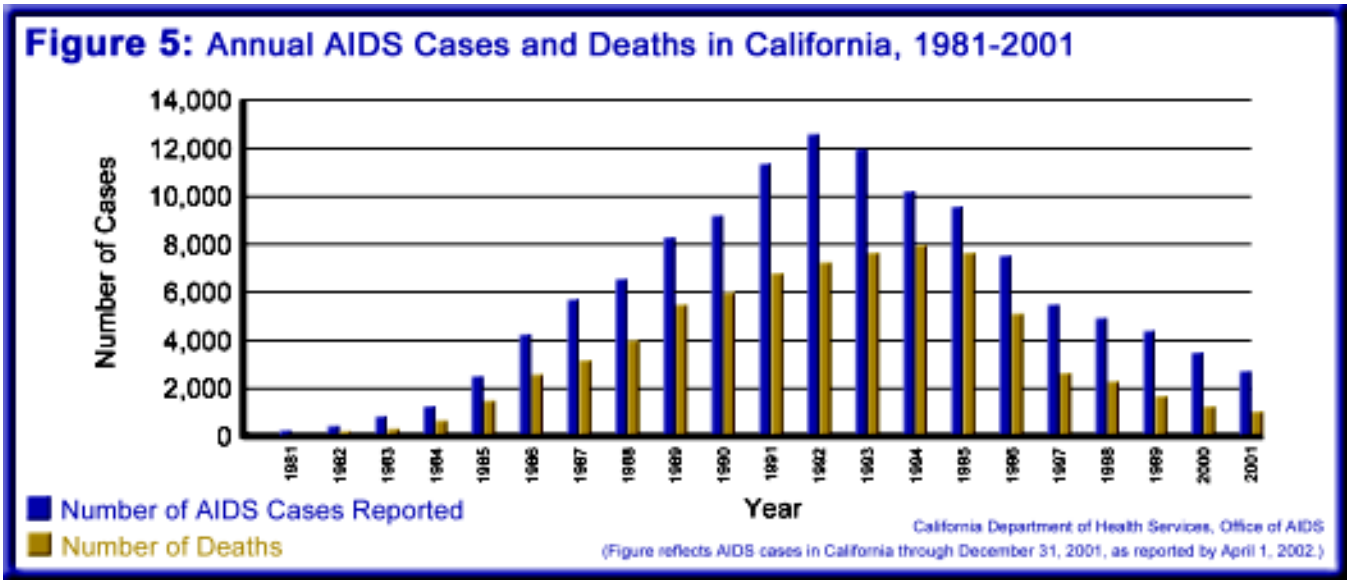
- California, compared with the rest of the nation, has a lower percentage of cumulative AIDS cases attributable to IDU (10.4% versus 27.5%, respectively) or heterosexual contact (4.8% versus 11.9%) (Fig.4).

Figure 4: National *versus* California AIDS Cases by Risk Factor



National Source: Centers for Disease Control and Prevention; Data includes all states but California

California Department of Health Services, Office of AIDS



California AIDS Registry data through December 31, 2001, and reported by April 1, 2002, reveal the following trends:

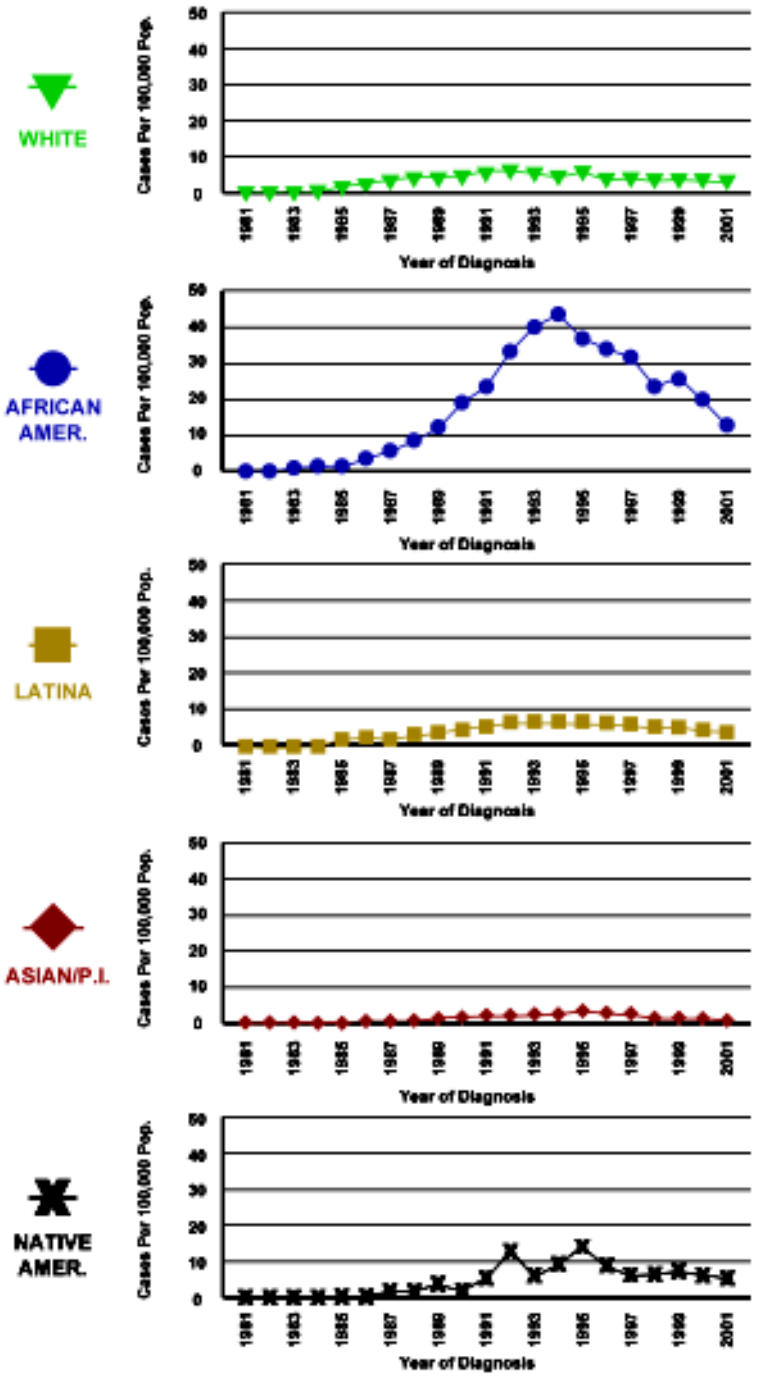
- Annually reported AIDS cases have been declining since 1993. From 2000 to 2001 annually reported AIDS cases declined by 8.1% (276 cases), following a 14.4% drop from 1999 to 2000 (Fig. 5).
- The number of annual deaths in 2001 (1,305) is only slightly lower than the 1,419 AIDS-related deaths in 2000 (Fig. 5).
- The survival time after an AIDS diagnosis has risen dramatically. The median survival time of reported AIDS cases diagnosed in 1993 was double that of reported cases diagnosed in 1988 (data not presented).

Annual Incidence Rates

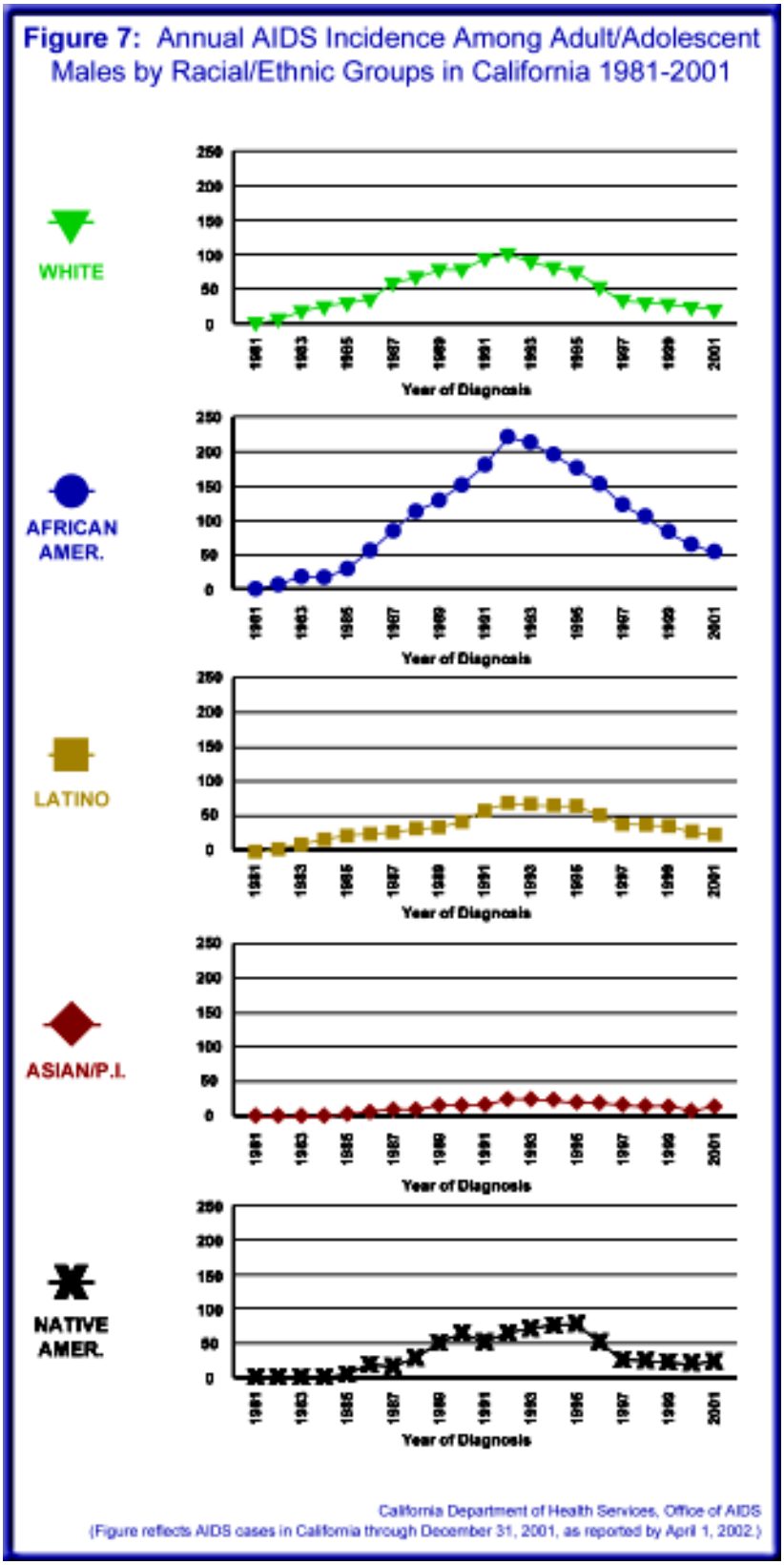
- In 2001, annual incidence rates (number of AIDS cases per 100,000 population) continued to decline for all racial/ethnic groups (Figs. 6 and 7).

- African American males (55.0) and females (13.6) continued to have the highest annual AIDS incidence rate among all racial/ethnic groups in 2001. The AIDS incidence rate for African American females in 2001 was triple that of Native American females, six times higher than among Latinas, and over ten times that of White and Asian/Pacific Islander females (Figs. 6 and 7).

Figure 6: Annual AIDS Incidence Among Adult/Adolescent Females by Racial/Ethnic Groups in California 1981-2001



California Department of Health Services, Office of AIDS
(Figure reflects AIDS cases in California through December 31, 2001, as reported by April 1, 2002.)



- Since 1997, Latino males have had a higher AIDS incidence than White males (Fig. 7).
- In 2001, the AIDS incidence among White males (14.7) was near that of Latino (15.7) and Native American males (18.1). The AIDS incidence among White females (1.2) continues to be among the lowest of all racial ethnic groups (Figs. 6 and 7).
- AIDS incidence among Asian/Pacific Islanders (6.4 males, 0.6 females) has been the lowest among all racial/ethnic groups for both genders since the start of the epidemic (Figs. 6 and 7).

Annual Cases by Ethnicity

- Whites composed less than 50% of California's general population for the first time in 2000, while they have composed less than 50% of new annual AIDS cases every year since 1997 (Fig. 8). In both 2000 and 2001, Whites have composed under 40% of new AIDS cases.

- African Americans have been the most disproportionately affected racial/ethnic group in California. African Americans made up just over 23% of annual AIDS cases reported in both 2000 and 2001, more than triple their 7% representation in the state's general population (Fig. 8).

- Since 1997, over 20% of all African American AIDS cases in California have been female, while the percentages of females among White, Latino, Asian/Pacific Islander, and Native American AIDS cases are 8.3%, 11.7%, 13.3%, and 16.8%, respectively (data not presented).

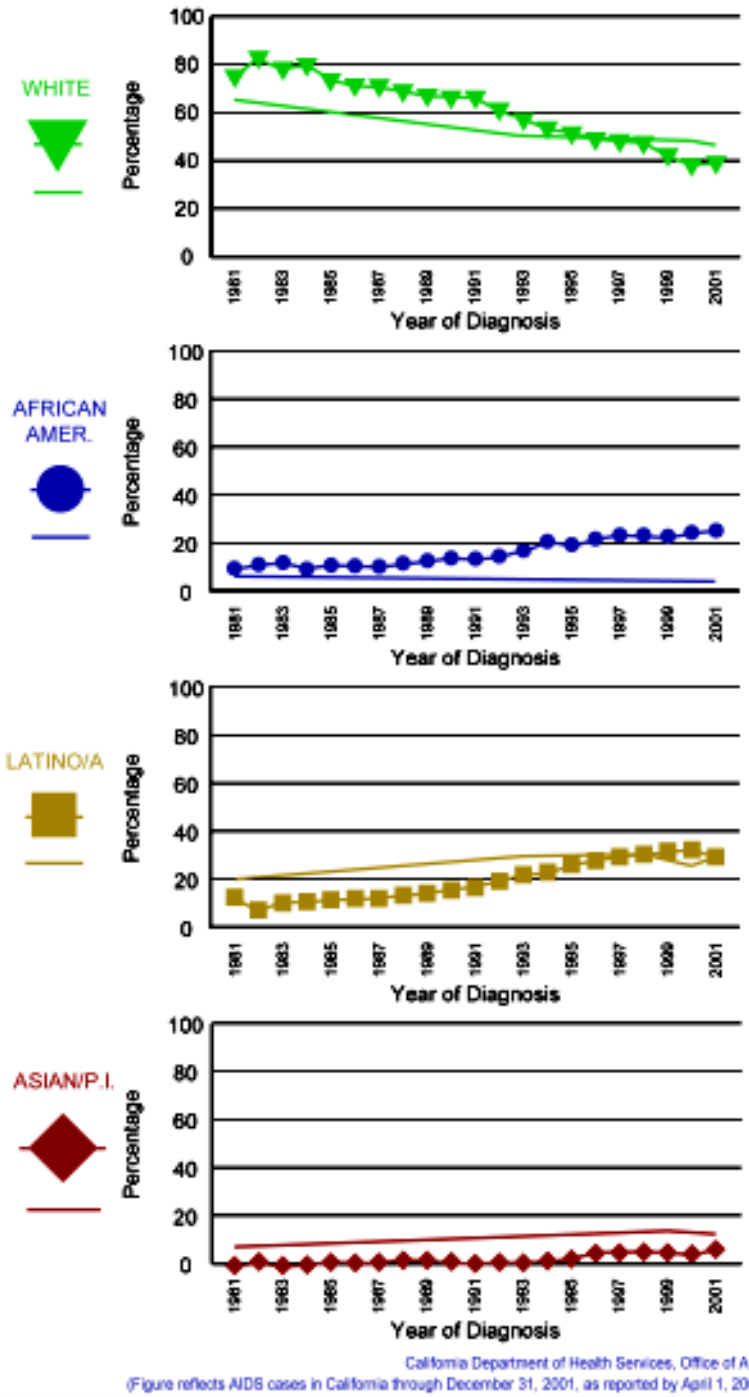
- The first time that Latino representation among new AIDS cases exceeded Latino representation in California's general population was in 1999. While under 10% of AIDS cases diagnosed in 1981 were Latino, by 1999 (and every year since then) this proportion was over 30%, representing a threefold increase (Fig. 8).

- The percentage of Asian/Pacific Islanders in the general population increased from about 6% in 1981 to over 11% in 2000 while the percentage among annual AIDS cases varied between 2% and 2.7% over the same period (Fig. 8). In 2001, however, this percentage rose to 4.0%. Asian/Pacific Islanders were the only racial/ethnic group with more AIDS cases in 2001 (126) than in 2000 (103).

- Native Americans represent about 0.5% of California's general population and about 0.6% of the annual AIDS cases reported in 2001 (data not presented).

Figure 8: Racial/Ethnic Group Percentages Among New Annual AIDS Cases and the General Population in California, 1981-2001

(Lines with shapes are % of new AIDS cases each year, solid lines are % of general population.)
*Native Americans not shown due to small percentages.



California Department of Health Services, Office of AIDS
(Figure reflects AIDS cases in California through December 31, 2001, as reported by April 1, 2002.)

Table 1: Percent of AIDS Cases Under the Age of 30 at Diagnosis by Gender and Racial/Ethnic Group in California, 1981 - 2001

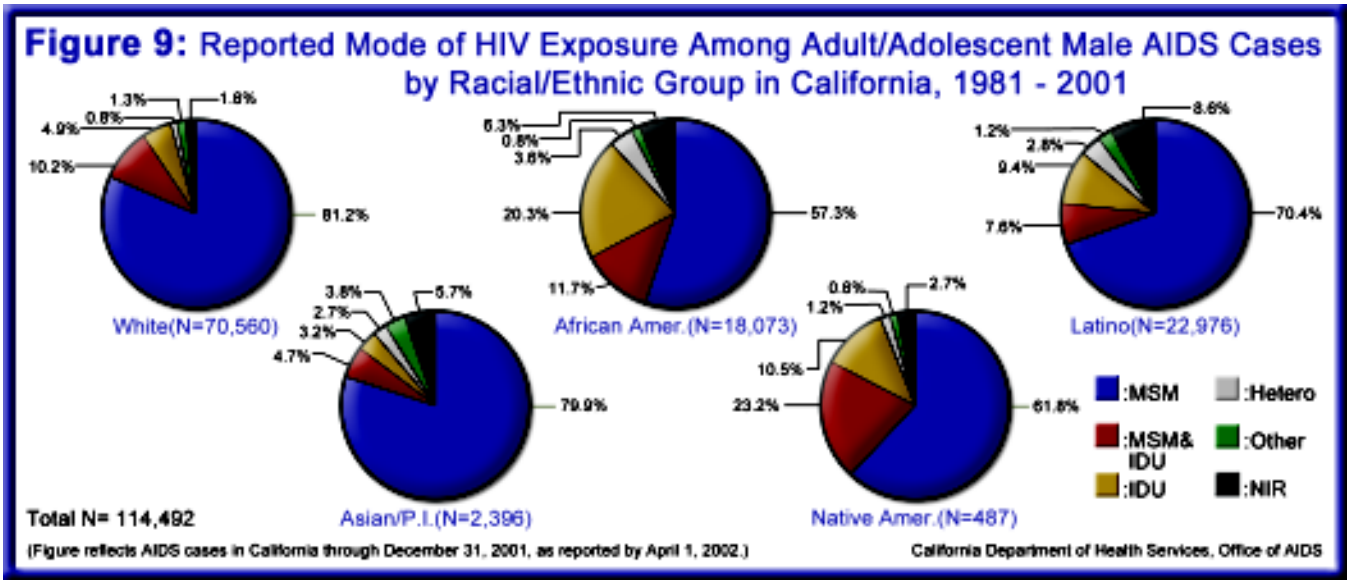
Racial/Ethnic Group	Male	Female
White, non-Hispanic	12.8%	22.5%
African American	15.9%	21.1%
Latino/a	23.5%	33.3%
Asian/Pacific Islander	17.0%	22.6%
Native American	22.2%	25.8%

(Figure reflects AIDS cases in California through December 31, 2001, as reported by April 1, 2002.)

California Department of Health Services, Office of AIDS

AIDS Cases Under the Age of 30 at Diagnosis

- Latinos are more likely than other racial/ethnic groups to be under the age of 30 at the time of AIDS diagnosis. Among Latinas, one-third of reported AIDS cases have been under the age of 30 at the time of diagnosis (Table 1).
- Among cumulative pediatric AIDS cases (617 cases total), 37.9% are Latino, followed by African Americans at 30.3%, Whites at 27.5%, Asian/Pacific Islanders at 3.1%, and Native Americans at about 1% (data not presented).



Mode of Transmission

- MSM (excluding MSM/IDU) represented 69.1% of the cumulative reported AIDS cases in California through December 31, 2001 (Fig. 4), and 54.1% of AIDS cases reported in 2001. While MSM remains the most frequent mode of HIV exposure, the percentage of reported AIDS cases attributable to MSM is declining (data not presented).

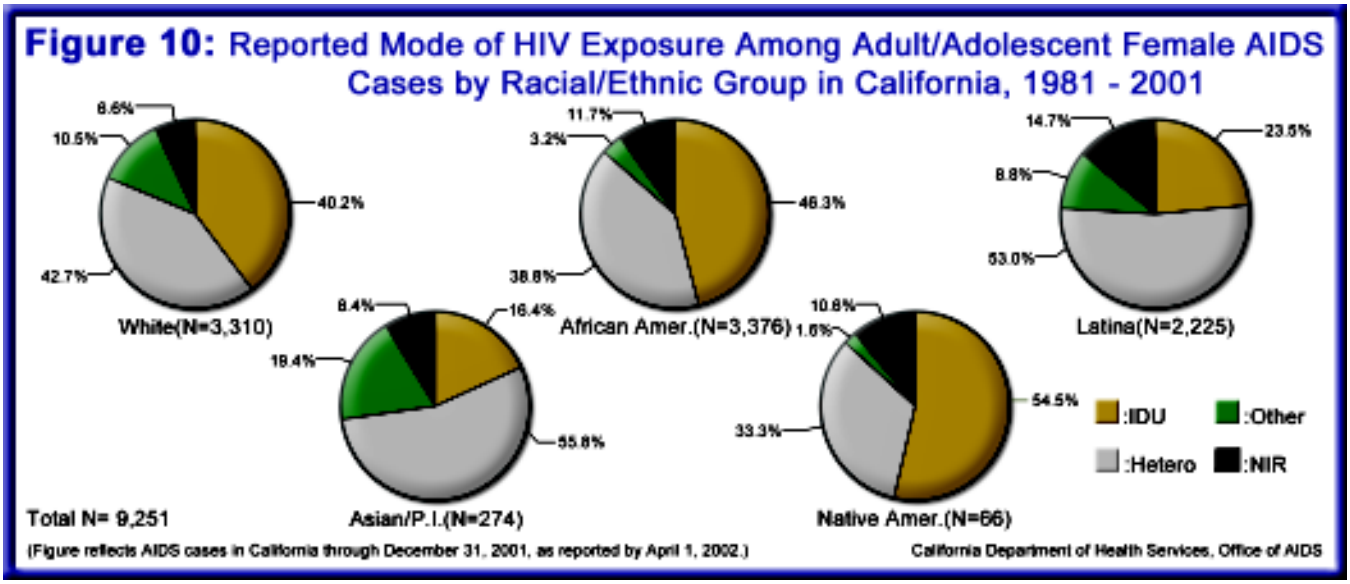
- Heterosexual transmission of HIV accounted for 4.8% of the cumulative number of AIDS cases reported through December 31, 2001 (Fig. 4), an increase of 0.2% since 2000, and slightly lower than the 0.5% increase from 1999 to 2000. Over 10% (320 cases) of AIDS cases reported in 2001 were due to heterosexual transmission (data not presented).

- IDU accounted for 10.4% of cumulative AIDS cases diagnosed through December 31, 2001 (Fig. 4). The percentage of annual cases reported with this risk exposure has exceeded 14% each year since 1999 (data not presented).

- The cumulative percentage of reported AIDS cases among MSM/IDUs remained at 9.0% in 2001 (Fig. 4), but the percentage of annually-reported cases has been below this mark each year since 1994. In both 2000 and 2001, the percentage of new cases reported with this exposure was 6.7% (data not presented).

- The proportion of AIDS cases reported with MSM HIV exposure vary across race/ethnicity groups, with Whites and Asian/Pacific Islanders about 80%, Latinos just over 70%, and African Americans and Native Americans between 57% and 62% (Fig. 9).

- The proportion of male AIDS cases reported with heterosexual IDU HIV exposure varies across race/ethnicity groups with a high of over 20% for African American males, about 10% for Latino and Native American males, and below 5% among White and Asian/Pacific Islander males (Fig. 9).



- Among cumulative female AIDS cases, over 53% of both Latinas and Asian/Pacific Islanders reported heterosexual HIV exposure, compared with under 43% for White (42.7%), African American (38.8%), and Native American (33.3%) females (Fig. 10).

- Female AIDS cases reported with IDU exposure fall into three tiers, with the highest among Native Americans at 54.5%, the middle among African Americans at 46.3% and Whites at 40.2%, and the lowest among Latinas (23.5%) and Asian/Pacific Islanders (16.4%) (Fig. 10).

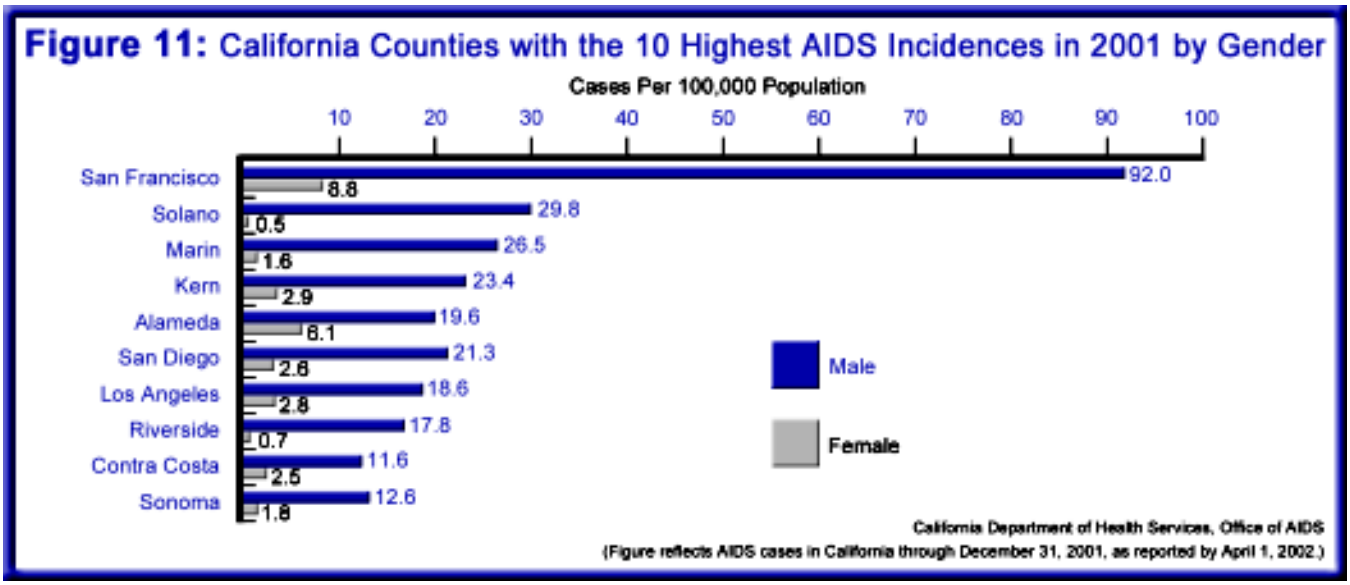
Regional and Graphic Distribution

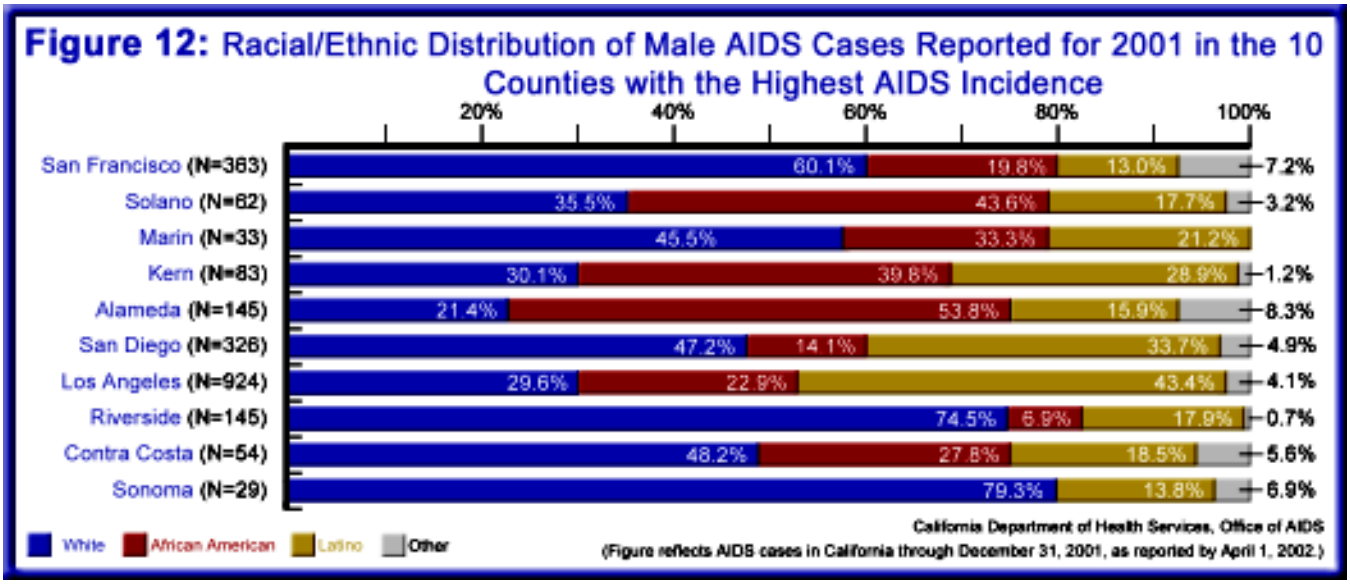
The ten counties in California having the highest AIDS incidence for both genders (Fig.11) include:

- Four largely urban counties: San Francisco and Alameda in the north, San Diego and Los Angeles in the south;

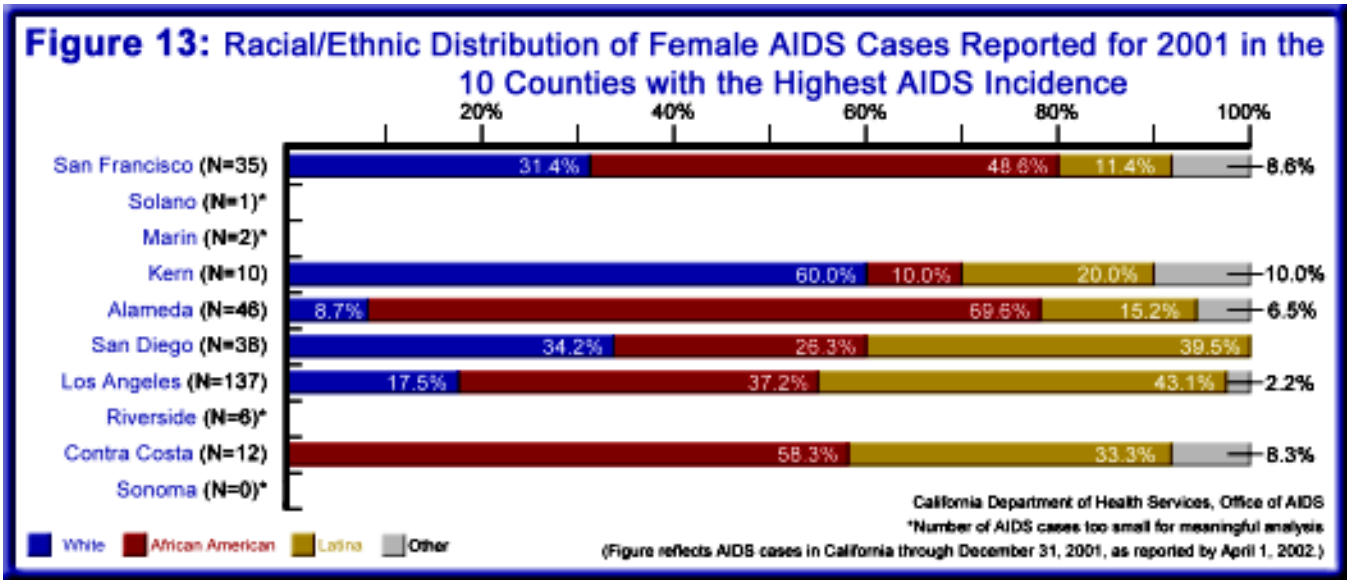
- Four largely suburban areas: Solano, Marin, and Contra Costa in the north, Riverside in the south; and

- Two largely agricultural areas: Sonoma in the north and Kern in central California.





- In the ten counties with the highest AIDS incidence for 2001, the majority of male AIDS cases were non-White in seven of the ten counties (Fig. 12). The majority of female cases were non-White in all seven counties that reported more than ten female AIDS cases in 2001 (Fig. 13).
- In 2001, at least one-third of male AIDS cases were African American in Alameda, Solano, Marin, and Kern Counties (Fig.12).
- In San Diego and Los Angeles Counties, at least one-third of male AIDS cases were Latino (Fig. 12).
- Among the six counties with at least ten reported female AIDS cases in 2001, over one-third of the cases were African Americans in San Francisco, Alameda, Los Angeles, and Contra Costa Counties, and over one-third were Latinas in San Diego, Los Angeles, and Contra Costa Counties (Fig. 13).



Young Men Survey

Methodology for the Young Men Survey was developed in 2000. This population-based, door-to-door survey, which began in late 2001 and will conclude in 2004, will study young men aged 18 to 35 years who reside in low-income neighborhoods within Alameda, Contra Costa, San Francisco, San Joaquin, and San Mateo Counties. The purpose of this study will be threefold:

1) To estimate the prevalence of important infectious diseases including HIV, syphilis, chlamydia, gonorrhea, herpes simplex virus types 1 and 2, hepatitis B, and hepatitis C;

2) To examine the association of specific sexual and injection/non-drug using behaviors with the prevalence of the infections; and

3) To assess the impact that demographic, attitudinal, and environmental factors have on certain risk behaviors as well as prevalence of infections.

Enhanced Perinatal Surveillance

Enhanced Perinatal Surveillance is the merger of two existing projects, the Pediatric AIDS Surveillance project and the Maternal Infant Care Evaluation project. This ongoing study covers children under 13 years of age who are HIV-infected or have known perinatal exposure to HIV (i.e., born to a mother with HIV infection documented before delivery with no history of blood or blood product transfusion before 1985).

The OA contracts with Stanford University School of Medicine to conduct active surveillance of records from hospital-based clinics and from HIV-positive pediatric patients cared for through the California Children Services Program to identify HIV-exposed and HIV-infected children. The 13 sentinel sites participating in the study cover all major referral centers in California outside of Los Angeles County. Study nurses record all patient data using a unique identifier. Information collected on each child includes demographic, clinical, laboratory, and social service data. Infant records are linked with maternal records to collect information about maternal characteristics, risk behavior information, prenatal care, treatment and services received, and HIV testing history. Patient records are updated at six-month intervals.

This study increases knowledge of the extent of HIV infection among California's children and contributes to the epidemiologic understanding of HIV infection and exposure in children. It provides an estimate of rates of prenatal HIV testing, treatment, and perinatal services received by HIV-infected pregnant women. The study's regional approach to pediatric HIV surveillance has been effective in assuring a standardized, thorough assessment of epidemiologic information. In addition, the study has been integrated into existing public health surveillance programs with the support of federal, state, and local public health officials who have access to all data generated from surveillance efforts.

A total of 1,207 infants exposed to HIV have been enrolled in the Enhanced Perinatal Surveillance system. Of these, 13% (n=154) are confirmed HIV-positive, 15% (n=187) have been diagnosed with AIDS, and 63% (n=760) have seroreverted. Of all pediatric cases enrolled, maternal records have been abstracted for 339 cases.

HIV Serosurveillance

In collaboration with 11 LHJs (Fresno, Kern, Los Angeles, Sacramento, San Bernardino, San Diego, San Joaquin, and Santa Clara Counties; the Cities of Berkeley and Long Beach; and the City and County of San Francisco), the OA supports HIV serosurveillance in selected STD clinics. Most sites are funded with state funds. The City and County of San Francisco and the County of Los Angeles receive funds awarded by the CDC. All of the sites conduct anonymous and blinded HIV testing. The objectives of HIV serosurveillance are to:

- Provide state and local health officials, as well as the public, with information on HIV prevalence in various populations;
- Assess the magnitude and extent of HIV infection by demographic and behavioral subgroup and geographic area;
- Identify regional and national changes over time in the prevalence of infection in specific populations; and
- Project the number of children and adults who will develop HIV-associated illness and require medical care.

In 2001, the OA completed the analysis of 1999 data collected from 19 STD clinics in 11 LHJs. These clinics tested a total of 17,620 serum samples in 1999. Statewide, the HIV seroprevalence at STD clinics was 3.4%, an increase from 2.4% in 1998. Men represented 67% (11,753) of the total STD population, of which 4.9% (575) were HIV seropositive. Women represented 33% (5,831) of the total STD population, of which 0.4% (25) were HIV seropositive. In 1999, the highest HIV seroprevalence (27%) was among MSM who inject non-prescription drugs, a notable increase from 19.0% in 1998. The second highest HIV seroprevalence was among MSM who do not inject drugs (19.1%), an increase from 16.5% in 1998. Heterosexual women showed a seroprevalence of 0.4%, compared with 0.5% in 1998. Among heterosexual females who inject non-prescription drugs, the seroprevalence was 0.9%, a sharp decline from 1.8% in 1998.

HIV Testing Survey

In early 2001, the OA and the CDC implemented the HIV Testing Survey (HITS), an anonymous cross-sectional study conducted in three high-risk population groups in San Diego, Alameda, and Sacramento Counties. The purpose of HITS is to monitor HIV testing patterns, assess why at-risk individuals seek or delay HIV testing, and identify what factors influence their decisions. Results of the survey will:

- Assist in developing specific interventions and prevention programs to help at-risk individuals overcome barriers to HIV testing; and
- Assess knowledge and issues surrounding state policies for HIV surveillance. HITS is part of the pre-implementation evaluation of California's HIV reporting system.

In December 2001, additional funds became available to expand HITS in order to improve understanding of HIV testing behaviors and perceptions in at-risk communities of color. In collaboration with the CDC, the OA developed plans for conducting HITS among migrant and seasonal farm workers in San Joaquin, Yolo, and Solano Counties. Implementation of this survey is targeted for early 2002.

HIV, Hepatitis B Virus, and Hepatitis C Virus Prevalence Study at San Quentin Prison

In March 2001, the OA, in collaboration with the CDC, the Viral and Rickettsial Disease Laboratory, the California Department of Corrections, and Centerforce, a community-based organization, implemented a study to measure the prevalence and incidence of HIV, hepatitis B, and hepatitis C among inmates of San Quentin State Prison. This study will also assess drug use and risky sexual behaviors for 500 incoming inmates who receive HIV counseling and voluntary HIV testing. The study is expected to end in 2003 and a report of the findings will be released in 2004.

Blood Banks and Plasma Centers

As statutorily mandated, the OA receives HIV antibody test results from blood banks and plasma centers throughout the state to determine the number of HIV-infected individuals that donate blood. In the first half of 2001, the confirmed HIV-1 positive rate for blood banks was two per 100,000 units, a marked decline from the 1990 rate of 51 per 100,000. Figures for the first six months of 2001 indicate a significant rise in reported blood donations and a moderate drop in HIV-infected units for both blood banks and plasma centers. Plasma centers continue to report higher HIV-1 rates than blood banks. This is generally attributed to the plasma center practice of paying donors for their blood, which may attract IDUs and others who engage in high-risk behaviors.

Civilian Applicants for Military Service

Since October 1985, all civilian applicants for U.S. military service have been required to undergo testing for HIV infection as part of their medical entrance examination. The most recent data available regarding prevalence of HIV among California applicants show a statistically significant decrease from 0.22% (26/11,990) in October 1985 to 0.02% (8/34,394) in 2000. HIV prevalence for 2000 was highest among male applicants in Fresno (0.14%), followed by Riverside (0.07%), San Diego (0.07%), and Los Angeles (0.06%) Counties. Overall, prevalence was highest (0.14%) for African American male applicants, compared with 1999 data when African American female applicants had the highest HIV prevalence (0.10%). In 2000, applicants in the age groupings 25-29 and 30-34 had the highest HIV prevalence (0.07%), followed by age group 20-24 (0.03%).

Surveillance for Variant and Drug Resistant Strains of HIV-1

The OA, in collaboration with the CDC and San Diego County, is conducting sentinel surveillance for variant and drug resistant strains of HIV. The study population consists of all untreated, newly diagnosed HIV-1 infected individuals aged 18 years and above who do not have a known AIDS-defining illness and are entering San Diego County Early Intervention Programs. The purpose of the study is to check for the introduction, and estimate the prevalence of,

variant genetic strains of HIV in California; and determine if viral genotype resistance to antiretroviral therapy (specifically, protease inhibitors [PI], nucleoside reverse transcriptase inhibitors [NRTI], and nonnucleoside reverse transcriptase inhibitors [NNRTI]) is transferred from HIV-1 infected persons receiving such therapy to uninfected persons.

Collection of blood specimens concluded December 31, 2000, and laboratory analysis was completed in 2001. Of the 39 specimens collected:

- One specimen was found to be subtype A (rarely found in the Americas);
- Two specimens showed primary mutations associated with resistance to certain AIDS drug therapies. Both specimens had mutations known to convey resistance to PIs (specifically the drugs indinavir and saquinavir); one of these specimens also had a primary mutation for two different NRTIs (specifically lamivudine and abacavir), while the other had a primary mutation for two different NNRTIs (specifically nevirapine and delavirdine); and
- Twenty-two specimens showed secondary mutations that are indirectly associated with resistance to drug therapies (by improving the fitness of HIV strains with primary mutations). Of these 22 specimens, 15 had exactly one secondary PI mutation, 5 had exactly two secondary PI mutations, and 2 had exactly one secondary NRTI mutation.

In summary, this study describes the epidemiology of antiretroviral drug resistance in San Diego, and suggests that HIV genotypic testing prior to the initiation of therapy in patients with infection of unknown duration would identify a substantial number of persons with HIV containing mutations associated with reduced antiretroviral drug susceptibility.

Binational and Border Health Activities

During 2001, in support of the California-Mexico Binational and Border Health Initiative, the OA, in collaboration with the Office of Binational and Border Health, LHJs, and el Centro Nacional Para la Prevención de VIH/SIDA developed plans to:

- Prepare and disseminate a joint report on the epidemiology and surveillance of HIV/AIDS in Mexico and California, focusing on the epidemic among Latinos and with discussion regarding the migrant population in California;
- Provide technical assistance and participate in training exchanges on HIV/AIDS surveillance, prevention, and care; and
- Identify funding sources to continue existing and initiate new epidemiologic studies on prevalence of infectious diseases, behavioral surveillance, and access to health care among migrants and Latino populations at the border.

In 2001, the OA, HIV Counseling and Testing Section conducted the first HIV counseling and testing binational training in Spanish. OA provided this training to outreach workers and promotoras from the Imperial and Mexicali Valleys. The training included a five-day Basic I training, a three-day Basic II training and, for participants that successfully completed both of these courses, a three-day Train-the-Trainer course. Participant manuals that were previously only available in English were translated into Spanish. Binational training allows more health workers from both sides of the border to provide counseling and testing in Spanish, thereby increasing the availability of HIV/AIDS services in both English and Spanish for Latino migrants and seasonal farm workers in the region.

Binational HIV Prevalence, Incidence, and Risk Behaviors Study

In 2000, the OA began data collection for a study to estimate HIV prevalence, incidence, and risks among 18-29-year-old Latino MSM who reside in San Diego, California, and Tijuana, Mexico. This study is funded by a 1999 award from the Universitywide AIDS Research Program. Study subjects were interviewed about sexual and drug use behaviors as well as attitudes related to HIV. In addition, blood was drawn from each subject for HIV antibody testing and, if HIV-seropositive, related tests such as CD4 counts, HIV viral load, and HIV subtyping were performed. The sample collection in Tijuana was completed in 2001 and data and sample collection in San Diego will terminate June 30, 2002.

HIV Prevalence, Incidence, and Risks Among Young Latino MSM at the California–Mexico Border; Imperial County, California and Mexicali, Baja California, Mexico

In 2001, the OA developed plans for conducting a study among young, Latino MSM at the Mexicali-Imperial border. With support from the health jurisdictions of Baja California and Imperial County, the OA will collaborate with the HIV/AIDS Division of the Imperial County Health Department and Project Concern International, a local community-based organization in Mexicali. Approximately 500 participants from each site will be recruited for the study. Participants will be interviewed using a standardized

questionnaire, and if they consent, a sample of blood will be drawn and tested for HIV antibodies. CD4 levels, viral load, recent seroconversion status, and genetic subtype will be assessed by further tests on HIV-positive specimens.

Together, San Diego and Imperial Counties compose California's border with Mexico. Although they are geographically adjacent, the two counties have very different economic and demographic structures. The data from this study in conjuction with data from the current Binational HIV Prevalence, Incidence, and Risk Behaviors study, will provide a more complete characterization of the impact of the California-Mexico border on risk behaviors and HIV transmission. This study will also provide a greater understanding of HIV-related attitudes and knowledge among Latino MSM in the border region. Implementation of this project is targeted for July 2002.

HIV/STD/Hepatitis Seroprevalence Survey among Homeless, Runaway, and Street Youth

In 2001, the OA conducted an anonymous, cross-sectional survey among homeless, runaway, and street youth between the ages of 16 and 24. Youth were recruited from community-based organizations located in Sacramento (Diogenes Youth Services), San Diego (Family Health Centers of San Diego), and the City of Berkeley (Berkeley Ecumenical Ministries Foundation). The results of this study are expected to be available in August 2002 and are to be presented as a statewide report in 2003. The objectives of the survey are to:

- Estimate the prevalence of HIV, hepatitis B, hepatitis C, herpes simplex virus type II, chlamydia, and gonorrhea;
- Assess sexual and drug-using behaviors; and
- Assess health care utilization patterns.

Surveillance Grant Program

Since 1986, the OA has provided state funds to 61 LHJs (58 counties and three cities) through the Surveillance Grant Program. With this funding, LHJs are able to develop and implement active AIDS case surveillance programs. Funding goals include:

- Establish, maintain, and/or enhance local health departments' active AIDS case surveillance efforts in hospitals, clinics, private physicians offices, immunology laboratories, and other medical/social service settings;
- Improve the timeliness, accuracy, and reliability of the local AIDS case data;
- Conduct epidemiologic investigations of selected cases for risk or other information;
- Assure the security of AIDS case data and all related information to maintain the confidentiality of infected individuals;
- Plan, conduct, and disseminate studies of AIDS morbidity and mortality in collaboration with other departments; and
- Monitor and direct AIDS case finding activities to ensure optimal use of surveillance resources.